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ABSTRACT

This newsletter theme issue addresses adoption and the young child's life. Contributors suggest ways in which practitioners in many professions and settings can better understand and support adoptive families. The first article, "Adoption, 1990" by Barbara F. Nordhaus and Albert J. Solnit, reviews the history of adoption and notes obstacles to serving the best interests of the child and such controversies as open adoption. The second article, "On Adoption" by T. Berry Brazelton, looks at the stresses on the adoptive parent and offers answers to children's questions about adoption. Remaining articles have the following titles and authors: "And Baby Makes Two: Adoption and the Single Parent" (Deane Argenta); "The 'Psychological Work of Pregnancy' in Adoption (Anne Williams); and Preventive-Intervention Groups with Adoptive Parents and Their Babies: Minimizing the Risks to Emotional Development in the First Three Years" (Elaine Frank and Denise Rowe). Also included in this issue is the 1989 report of the National Center for Clinical Infant Programs which covers Center activities, a financial statement, and a list of contributors. (DB)

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[Adoption]

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Adoption, 1990

by
Barbara F. Nordhaus, M.S.W.
Albert J. Solnit, M.D.
Yale Child Study Center

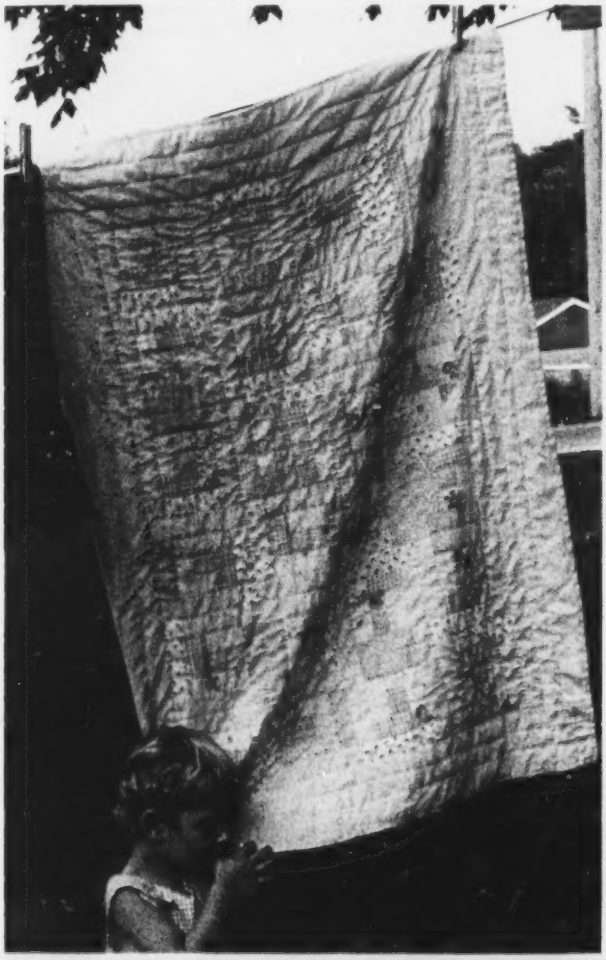
Contemporary adoption is a powerful human engagement, an institutionalized process that is significantly influenced by the historical, cultural and developmental contexts in which it takes place. It is a process that society has designed to insure the best interests of unwanted children. The process, as it evolves, reflects both our best knowledge and preferred societal values.

The terms used to refer to non-family adoptions reflect changing emphases on many aspects of this human "experiment" at different times. In the literature we see terms such as "shared fate"; "adoption triangle"; "search for origins"; "open adoption"; "closed adoption"; and "the chosen child" used to describe concern for the adopted child, the biological parents, and the adoptive parents. In this report, we emphasize the best interests of the adopted child.

The adoption process is best initiated when the child is a newborn, when the biological parents have decided to cooperate with the process, and when highly motivated adults have been prepared and qualified to become adoptive parents before the birth of the child. The earlier the adoption, the more closely it simulates the desirable parent-child relationship. Under ideal conditions, adoption provides the child with continuity of affection and care, stimulation, and protection, leading to trust and confidence in the adult caretakers. It provides the adoptive parents with satisfying responsibility, fulfillment, and permanence in their relationship to the adopted child.

Historical roots

Adoption of newborns in modern times became a legally and medically sanctioned process in the late



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1920's, with the availability of safe and nutritionally balanced milk formulas (Project Share, 1986). As demographic changes have resulted in a shortage of adoptable newborns in the United States, there has been a shift toward adopting older children, children with special needs, and children from other countries. Placement as early in the child's development as possible requires energetic and imaginative efforts by public and private agencies

The practice of adoption itself can be traced to ancient times, when children in some cultures were regarded as the property of their parents. In Roman society, for example, parents had the legal right to abandon their children. When they did so, poverty was usually the reason. Abandoned children were often taken in and reared with affection as foster children, and sometimes treated as biological heirs by childless couples. Children could be bought. Some acquired value as concubines after age 12 and as laborers at any age (Boswell, 1990).

We have moved from vaguely humane efforts to protect unwanted or abandoned children from death or exploitation to an articulation, in law and custom, of principles "in the best interests of the child."

Gradually, during the Middle Ages, specialized religious orders began to undertake the care of the poor, the sick and the homeless. Hospitals began to accept abandoned children, "foundlings." Foundling homes were established, with the desirable result of protecting abandoned children, but with the undesirable effect of creating emotionally deprived "classless, familyless, unconnected adolescents with no claim on the support or help of any persons or groups in the community" (ibid, p. 421).

As lineage and blood ties became more central in political and economic life, adoption became less desirable. The non-biological child was viewed as inferior. In this country, children who were not cared for by their families were often indentured, and worked without protection until the passage of child labor laws.

The organization of twentieth century Western society and the regulation of family life reflect significant changes in values. We have moved from vaguely humane efforts to protect unwanted or abandoned children from death or exploitation to an articulation, in law and custom, of principles "in the best interests of children." Best interests also imply the constitutional guarantees of the privacy of the family and the autonomy of parents.

Obstacles to serving the best interests of the child: Cindy

Cindy's story illustrates many of the obstacles to serving the best interests of the child that are often seen in the adoption process. In her case we see: 1) the power of early attachment and the damage done when the attachment is broken; 2) the riskiness of basing long term predictions on sociological norms or assumptions about race; and 3) the capacity for simple passage of time to harm development.

Cindy, the light-complexioned child of a black mother and white father, had been placed in a foster home soon after birth. Her foster mother, Mrs. T., was a black widow in her mid-forties who lived with a boyfriend. Her only child was in his early twenties and living away from home. Mrs. T. suffered from mild hypertension.

Zero to Three Staff
Editor—Jeree Pawl Associate Editor—Emily Schrag Fenichel
Consulting Editor in Pediatrics—Jack Shonkoff

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When Cindy was 20 months old, a state social worker informed Mrs. T. that Cindy would have to be taken away from her, as she was eligible for adoption. It developed that a white, middle-class family had been identified as interested in adopting a child like Cindy. The state child welfare department decided that, in the long run, Cindy would be better off with that family than with Mrs. T.

Mrs. T., who wanted to adopt Cindy and had been refused, manifestly because she was a foster mother, asked the local legal assistance agency for help in resisting this loss of her child. With the approval of the court, the legal assistance agency mobilized a distinguished panel of experts, who prepared a thorough clinical evaluation. Following the principles of "continuity of affectionate bonds" and "the least detrimental alternative," as well as indicating their preferences for giving primacy to Cindy's immediate needs, the panel indicated that the long-term prediction of a better long-term future in our society was no substitute for maintaining and protecting the continuation of Cindy's rights to remain with the only mother she had ever known. The panel members sealed their recommendation with a report of the excellence of Cindy's development.

The first judge in the case, however, decided in favor of the State Department of Social Protective Services. At the age of 26 months, Cindy was forcibly taken away from her mother and placed temporarily in another foster home. During the next six months, while appeals were being prepared and filed, Cindy's development moved backward. She was depressed and lost ground in her social, verbal and neuromuscular development. The appeal was strengthened by the experts' findings of what this rupture of Cindy's relationship to Mrs. T. had cost the child.

No one formula or recipe can apply to all adoption circumstances. We are convinced that there are an infinite number of ways in which the best interest of the child can be served in the adoption process.

At the appeal, in a second court, the action of the state was upheld. Cindy was assigned to adoptive parents. However, the adoptive parents were informed that one more appeal could still be filed with the state Supreme Court, and that they should not assume that Cindy would be theirs to adopt until that appeal, should it be filed, was decided. This precautionary note was intended to modify the full involvement of the new parents until the adoption was assured. Once more Cindy was deprived of her right to feel an unqualified continuity of affectionate parental investment.

The legal assistance agency proceeded to prepare the appeal. By that time, Cindy had been away from Mrs. T. for 13 months. Although the experts had initially decided to support the second appeal, they changed their minds after they reviewed the meaning of "least detrimental alternative" for Cindy in the light of the passage of time for a child under the age of three years (Solnit, 1977).

Editors' note:

The essays in this issue of *Zero to Three* reflect the complexities of adoption in the United States at the beginning of the 1990's. Written by professionals who have witnessed (and contributed to) changes in adoption policy and practice over many decades, by innovators in services to adoptive families, and by parents currently in the process of adoption, these articles offer no simple formulas. Rather they describe the impact of aspects of the adoption process on individual adults and children, and on their relationships. Drawing on their personal and clinical experiences, the contributors to this issue suggest ways in which practitioners in many professions and in many settings can better understand and support adoptive families, especially in their earliest years.

A number of contributors to this issue note that societal attitudes about adoption have changed, but still remain ambivalent. Perhaps this is partly a reflection of our considerable societal turmoil regarding child rearing in general as well as a continued failure to truly accept the integrity, needs and rights of children. It remains unclear how much our society really values children or how much it is willing to support and nurture all those who choose to become families, caring for children—whether biological, adoptive, "intact," blended, extended, foster or any other constellation.

While adoption by her new parents may have represented the least detrimental alternative available to Cindy at three years, a far better option, consistent with our knowledge of development, would have been to accord Cindy's long term placement with Mrs. T. the status of a de facto adoption. In an earlier work it was proposed that the process of adoption, de facto or de jure, "... be made final the moment a child is actually placed with the adopting family" (Goldstein, Freud, and Solnit, 1979, p. 36). Since Cindy had been placed with Mrs. T. soon after birth and had been with her continuously throughout the first twenty months of life, Mrs. T. had become the de facto adoptive parent. Cindy's placement with Mrs. T. should have been viewed as a permanent placement and an adoption order instituted with the same finality conferred by a birth certificate.

No one recipe: John

The adopted child often copes with feelings of abandonment, and with fantasies and yearnings about idealized parents, as well as with the mysteries of the life that would have been led had things been different. "Who am I?" "Who was I?" "Who shall I become?" represent aspects of the never-ending mutual and reciprocating search by all children and their parents.

When adoption proceeds adaptively and healthfully, the process and its influences can be relatively silent. No one formula or recipe can apply to all circumstances—not even one concerning how adoptive children should be informed about their adoption.

While trying to plan for his college major, 18-year-old John found himself attracted to volunteering for a social agency that specialized in adoption. Through his work, he became aware of the meaning of sealed records. This led him to wonder, as so many children do earlier in their lives, whether he had been adopted.

Fantasies of having been born to royalty are common. As the myth goes, the royal family, in order to protect the child from the perils of fame, gives their infant to good folks who will take care of him until he is older. That John's early childhood took place during the Lindbergh kidnapping case may have made such fantasies even more common among his peers than in other generations.

John asked his parents if he had been adopted, consciously expecting them to say no. To his great surprise, they acknowledged that they had adopted him soon after birth. With considerable anxiety and resentment, he asked why they had not told him—he had already learned in his volunteer work that such advice was given to adoptive parents at the time. His parents explained that they had felt he was truly their son since the first day they held him. They had seen no reason to tell him of the adoption.

Over the next 20 years this young man became a successful professional, husband and father. His initial resentment became transformed by his sense of humor. "After all," he said, "while they shouldn't have done it, they really didn't know better. Anyhow, I turned out pretty well!"

John's story demonstrates the idea of adoption as a dynamic process. The "noise" of some adoptions should not obscure the fact that many adoptions proceed silently and well. Moreover, the experience of adoption cannot be separated from the complexity and uniqueness of each individual—how his past and his present are represented in the psychological meaning of adoption to *him*.

Open adoption and other controversies: Only one right way?

The controversy surrounding "open" and "closed" adoption of infants underscores the complex choices facing biological and adoptive parents. As defined by Baran and Pannor (in Curtis, 1986) open adoption is "a process in which the birth parents and the adoptive parents meet and exchange identifying information. The birth parents relinquish legal and basic child rearing rights to the adoptive parents. Both sets of parents retain the right to continuing contact and access to knowledge on behalf of the child" (p. 438). The complexities of such a process have been discussed most recently by Lincoln Caplan in a two-part article in *The New Yorker* (1990).

We are convinced that there are an infinite number of ways in which the best interest of the child can be served in the adoption process. Our knowledge contradicts the belief that there is only one right way. If the adults involved—biological and adoptive parents—are in agreement, and their agreement is consistent with their value and life-style preferences, either open or closed adoption can work well. What overrides all other considerations for adopted children are the principles that children need to feel wanted, and to have continuity of affectionate care and a safe environment on a permanent basis.

Human beings to prefer linear explanations to the mysteries of mosaics. So 40 years ago adoptions were postponed until babies were at least eight or nine months old, so that the child's biological, developmental "equipment" could be assessed quantitatively with sufficient precision to match the child with appropriate adoptive parents. Attempts were made to match adoptive parents who were college graduates with children who were "known" to have the potential to complete a college education.

Today we "know" that the child's potential can be jeopardized significantly by late, rather than early, placement with adoptive parents. Our best knowledge now indicates that, in order to protect his developmental potential, a child should be placed early with parents who want him. "Matching" can be a pitfall. Although we will no doubt continue to debate the relative importance of nature (genetics) and nurture (psychosocial environment), both are important. We can continue to learn from the mosaics they provide.

It is crucial for all children to have permission and support to be curious and imaginative. Children should be helped to know as much about their lives as they wish to know and are able to usefully know.

Our own experience tells us that it is crucial for all children, including adopted children, to have permission and support to be curious and imaginative. Children should be helped to know much about their lives as they wish to know and are able to usefully know. This position takes into account that parents (biological or adoptive) have the responsibility and authority to decide how they want to raise their children.

In this way, all parents, including adoptive parents, can be assisted in minimizing the impact of their own blind spots, loyalty conflicts and fears.

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On Adoption

by
T. Berry Brazelton, M.D.

Excerpted from **On Becoming a Family**

Attachment to an adopted child can be surprisingly complex. Parents who have waited and searched for an appropriate baby are bound to feel they are ready to give their all to this baby. It comes as a surprise when they and the longed-for baby can't make it with each other right away.

Most parents who adopt have been through a devastating fertility workup. Being examined repeatedly, being searched for defects, is bound to undermine any adult's self-concept. The kind of personal investigations and the questions which imply that there is a psychosomatic defect must raise the question of adequacy to be able to parent. This confronts all parents, but is particularly vital to an adopting parent. As one accepts the responsibility for another person's child, the question of one's inadequacy is more likely to be heightened. The zeal to provide an endangered child with a safe haven covers up these insecure feelings for awhile. But this needs to be seen as a motive which will help only initially. The underlying questions about one's adequacy will surface as the work of attachment proceeds.

Stresses of the search

A prospective parent today must search at home and abroad for an appropriate baby. Too few agencies can be trusted. There are limited choices available. The question of using a surrogate parent to produce a child forces a parent to face his or her own inability to supplant the child's natural parent. Anticipating the conflict of competing for the child with a known parent must be a major reason for rejecting the idea of surrogacy. Recent legal struggles for custody, such as those raised by Mary Beth Whitehead, make following the path of surrogacy even harder. Parents whom I interviewed in my book, *Families: Crisis and Caring*, told me of the long, complicated search they went through to find an agency they could trust. Waiting lists were eight to ten years long. A few agencies could be paid large sums for an immediate baby. The financial corruption which families had to confront in many United States agencies devalued their goal. If they gave up the idea of adopting a Caucasian child, they found the same corrupt process when they turned to foreign adoptions. Babies were treated as marketable. If you were willing to accept an impaired infant, you could get a "bargain." An intact child would be expensive. This horrified hungry parents.

When prospective parents were able to identify an agency with whom they could work, the questions about their life style began. Were they really able to live up to this precious responsibility? Why had they turned to adoption? Had their own chances at natural parenting

FLORENCE SHARP

been explored completely? Too many parents adopt and then find they become pregnant. Even after a diagnosis of "hopeless" infertility, something about making the decision to adopt frees physical and even psychological forces, which may not be identifiable in an infertility workup. As the agency delves for reasons not to give you a baby, a parent also questions his or her motives. Why am I this ready to be confronted? Am I really adequate? As the self-questioning proceeds, the resolve is strengthened. The motives become more fervent. One dare not question one's adequacy. Any chink in one's armor would be found by the "agency" and the chance of an adoption curtailed. A waiting parent builds up to a hunger which could be equated with passion. By the time a baby is found, the parents-to-be are aware only of the hunger and of the long wait to satisfy it. They are ready for any baby. The usual work of readying oneself in pregnancy has been submerged. Only one motive is experienced—a readiness to fall in love with that baby.

The initial adjustment

The younger the baby, the easier the adoption. Not only does a newborn's appearance demand a kind of adult response to nurture, but the vulnerability of the newborn is bound to appeal to hungry parents. They can easily fall into a passionate bonding to a newborn. Every movement, every response is greeted as miraculous. Parents who are lucky enough to make a newborn adoption know that they are in a better position to shape this baby's future to fit into their own family. It is easier to develop as a parent when one starts with the newborn.

An older infant will have been in a placement before the adoption. As he or she is moved into the waiting family, the baby must make a new adjustment. A baby of any age must withdraw in order to make this adjustment. Even a four-month-old has adapted to the environment he or she has been in. Expectancies have

already been developed. When the environment changes, the baby must readapt to new expectancies. New noises, new faces, new rhythms must replace the ones to which the baby has become accustomed. It is well-known that the baby will have to "grieve" over the lost environment in order to readapt to the new. Part of grieving will be a kind of withdrawal on the baby's part. He or she will become unavailable to usual stimuli for a period. The more attractive the stimulus, such as a tender voice, a loving face, a nurturing cuddle, the more it will remind the baby of the previous nurturant. Even when the previous placement has been relatively empty and depriving, the baby will have made an adaptation. Nurturing cues cause the baby to pull away. The defenses are likely to be gaze aversion, arching of the body, crying in protest, or sleeping a great deal.

One of the adoptive families described in my recent book, *Families: Crisis and Caring*, was able to verbalize this poignantly:

"She was three months old when we got her from Korea. We hadn't any idea what her life had been like before we got her. We only knew what they told us, that her mother had been healthy, and that she was born normally. But I wanted to know so much more.

She was sent in Korean clothes and she arrived looking like a quietly alert Korean 'doll.' She was perfect to start with, and I knew that anything that went wrong was due to my mishandling. The first time she cried after she came, I did not know what she wanted. I wondered what she was asking for, and I knew it must be part of her past routine. She'd lived a whole life before I got her. Fortunately, I fed her, and she quieted down. I can't tell you how grateful I was—to her. I just kept wondering what I'd have done if it hadn't worked. That first day was a nightmare of uncertainty."

An adoptive parent who is prepared for this period of withdrawal and adaptation can understand the baby's negative cries. If she doesn't understand, she is likely to take these behaviors personally. The initial period of meeting a new adoptive baby can be painful unless the baby's need for time to adjust is considered. New parents are bound to enter this period with enthusiasm and excitement. Their need for the baby is at its peak. In the effort to meet this need, they are bound to overwhelm the new baby with well-intentioned stimuli. "We are so glad you are here! Look me in the face! I can't stand to put him down! Why is he turning away from me? Doesn't he like me?"

The parents' eagerness to bond with the new baby is met with hypersensitivity and averting responses. Any parent would feel rejected. The vulnerable parent who has been through fertility tests before he or she has decided to adopt is likely to be ready for rejection. Professionals can prepare parents for this period of reorganization and can urge them to wait to satisfy their hunger until the baby is ready. The baby's own hunger for attachment will then make the transition smoother.

When things go wrong

When things go wrong, a new, vulnerable parent is bound to look for a reason. Parents are likely to "scapegoat" the unknown—the baby's past. Although it is a defense, it is likely to cover up intense feelings of inadequacy. Parents-to-be today know so much about intrauterine conditions and their effect on the developing fetus. We know now that intrauterine malnutrition can interfere with as much as 40 percent of the number of cells in the fetal brain, the thyroid and adrenals (organs important to activation and paying attention). Drugs, alcohol and smoking by the pregnant mother have powerful effects on the behavior of the neonate. In former days, a parent might assign difficult behavior in the adopted baby to "poor genes." Now, when things go wrong, a new parent is liable to wonder whether the baby hasn't had a depriving pregnancy.

The combination of a fantasy of the mother who would give up her baby with the likelihood of her damaging behavior while she was carrying this rejected fetus can lead to a label in the adoptive parents' minds. As long as things go well with the baby, the label isn't necessary. But any deviance on the baby's part, causing turmoil in the parent-infant relationship, can too easily lead to the label of "less-than-perfect baby." For example, the intractable, fussy period that occurs in most infants in the first 12 colicky weeks can lead to an unconscious reaction in new, eager, stressed parents. They think, "Uh, oh—she's not an intact baby. Is she already damaged?" Instead of looking for the reasons for such normal deviations as fussiness each day, an adoptive parent might all too easily assign a label of "imperfect" to the baby.

Understanding this tendency in themselves might prevent this labeling. The initial period of adjustment is bound to be stressful for parents who really care. Adoptive parents need extra support and an understanding person who can evaluate conflicts at each period of stress. Given support and understanding of the normal deviations that any new baby will make, parents can recover. The question of heredity will go underground again.

All through childhood in an adoptive family's experience, questions about the heredity and the prior experience of the baby must be balanced in a parent's mind. Questions of his or her own adequacy to meet the parenting needs of this child will arise at each stress. Natural competitive feelings arise at each period of readjustment—"Would she have been better off in her natural environment? Have we failed?" A biological parent will recognize that questions about adequacy arise in every parent's mind as he or she questions failure with a child's adjustment. In an adoption, the tendency toward vulnerability and toward a sense of personal failure is liable to be enhanced.

Feeling like a "real" parent

When does one begin to feel like the infant's "real" parent? When does a parent become less vulnerable to the issues of "Will she want to look up her natural

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parents someday—and desert me?" "Will her birth mother come and take her away from me?" " When should I tell him he's adopted—and not really mine?" " How do I tell her? Will she then reject me?" "How do I protect him from the feeling of rejection he will get when he knows his natural mother gave him up for adoption?" "How could she do it?"

These questions are in the back of every adoptive parent's mind. They overlie the feeling of insecurity which accompanies the process. Feelings of competition with the birth parents are bound to be there. The more an adoptive parent learns to care, the more threatening these feelings can become. An understanding of these feelings frees up a parent to enjoy the process of attachment.

When the adoptive parent gets beyond the magic of falling in love and enters the working phase of staying in love, then he or she will feel like that baby's "real" parent. Adoptive parents tell me that when they've handled a few crises and have survived them, they are no longer vulnerable to a child's question: "Are you my real mother?" They know they are the parents that child needs.

Cross-cultural adoptions

In a cross-cultural adoption, all of these issues are likely to be enhanced. The parents' necessary search has been enlarged to cover other countries. As one gives up the idea of an adoption of a child of one's own race, the conflict about identity and the identity of the "other" is raised. "How secure am I about my own cultural identity?" "What do I bring to this child that I value and want to perpetuate for him or her?" "What will the child bring from his or her culture? How much should I try to perpetuate the values of that culture?" "Should I become bilingual in an effort to perpetuate his or her language?"

A baby from a distinct gene pool is likely to arrive with different rhythms and behaviors. These will subtly or unconsciously affect his reactions to the parents' understanding of him. For example, Japanese and Chinese babies observed in Asia using my Neonatal Behavioral Assessment Scale (NBAS) have demonstrated qualitatively different behaviors. Their motor behaviors are more fluid, slower and smooth. There are few startles or tonic neck reflexes which interrupt this behavior. Motor intensity is low, compared to other groups of babies I've seen. As a result, motor behaviors do not interfere with prolonged periods of attention. These alert state babies are likely to pay attention to auditory and visual stimuli for significantly longer periods. However, the auditory and visual stimuli must be reduced in intensity and in rhythm in order to capture the baby's attention. If the stimuli are too loud or too rapid, the baby will quickly shut them out, or will overreact by screaming loudly and inconsolably. The crying state can be impenetrable in Asian babies. The same prolonged state change is used in a crying state as in an alert state. Oriental babies can be difficult to console and may need to be fed more often and played with more quietly. Rhythms of attention and of movement are slower, more liquid and lower-keyed.

On the other hand, African babies in Zambia and Kenya were excited by motoric play. As they moved, their movements were now vigorous, and seemed more directed. Hand-to-mouth and self-consoling seemed easier in African babies. They seemed to love to be played with and to be handled. In an alert state, they were more excited by visual and auditory stimuli, as well as kinesthetic handling. As they watched and followed a face or a red ball, they would become more intensely alert, to throw off a startle or a tonic neck reflex. These reflexes interrupted the period of attention. The baby then needed to be contained, quieted in order to continue to pay attention to visual and auditory cues. State control and periods of attention were more easily interfered with by this motor reactivity. In the United States, Black American babies are likely to demonstrate some of the same motor excitement, the same intensity of interaction with sensory displays from the environment. More containment, more reinforcement of self-consoling patterns, such as hand-to-mouth activities, may be necessary for a period of interaction with a new parent.

What new parent would anticipate these differences in the threshold necessary to capture the baby's attention, and in the rhythms and intensity necessary to maintain an interaction? If the new baby's readjustment and period of withdrawal after he or she comes into the adoptive parents' home is prolonged, both the baby's patterns and the parent's expectations are disrupted. If we are to prepare adoptive parents for a cross-cultural adoption, we must warn them about the first period of regression and readjustment on the baby's part. In this period, trained professionals could teach new parents to observe, detect and respect the baby's innate threshold for taking and utilizing stimuli

from the environment. The baby's rhythms of attention and disengagement, which may well differ from those of the adoptive parent, can be demonstrated to the parents and learned by them. These insights into subtle behavioral differences could ease adoptions significantly. Not only would parents learn how to observe and interact with their new baby, thus increasing their own sense of competence, but they would also demonstrate their respect for the baby. The baby's responses, in turn, would give new parents the feedback of successful interaction which would cement them to the baby. The process of attachment would be started successfully, and both infant and parents would be able to build on it—feeling success as it developed over time.

Conclusion

The process of adoptive parenting is bound to be complex. The more parents care, the more any failure in the baby's progress is likely to affect them. Any deviance is likely to recall the sense of inadequacy ("When will it be my baby?") and to revive defensiveness ("Is this what the bad genes brought with them? Was there a defect in genetic or intrauterine exposure that this behavior represents?"). Any caring adoptive parent may well fall back on such questions, which are unnecessary if parents can be aware of the need for these questions as their own defense, and if they can be helped to see deviations in the child as normal. In other words, the vulnerability of the adoptive parent will need to be expected, and to be dealt with at each developmental crisis. Such an intervention will serve to protect the parent-child interaction and will give the adopted child a chance for the best potential outcome.

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Telling a child he is adopted

When do you tell a child he is adopted? My feeling is that you never don't talk about it. In order to be able to talk about adoption without negative feelings, a parent needs to make his or her own adjustment to the adoptive role. Hence, an early adjustment to the phases of becoming a family enhances one's readiness to talk about adoption when the child is a bit older, and as the child raises questions. Questions may come up as early as age four or five, and they keep occurring.

Q. Are you my real mommy or daddy?

A. I am your mommy and he is your daddy. We have loved you ever since you came into our lives. We shall always be there, and you will always know we are really parents for you.

Q. But you didn't birth me. Doesn't that make someone else my real parents?

A. That's right. We didn't have a chance to birth you. We both wish we had. Maybe you wish it, too. But we did have a chance to choose you. From the moment we saw you, we fell in love. We wanted to be your parents, and we wanted you to be ours. If anything, we were surer because we chose you. you are ours.

Q. Why did my birth parents give me up? Didn't they love me?

A. They must have had very good reasons. They must have been desperately unhappy about giving you up. Do you worry about whether they gave you up because they didn't love you? Yes. That's just not possible. You are so completely lovable that no one could give you up for that reason.

Q. But if I'm bad or don't do what I should, will you give me up?

A. No. Absolutely not. We love you under any condition. Even when we don't love what you do, we love you. There's a big difference. That's what love is all about. You may not love what they do, but you can still love someone unconditionally.

Q. My friends tease me about being adopted. They say I don't even look like you. They say I don't even know what my real parents are like.

A. But you do. We are your real parents. Someday you may even want to meet your birth parents, if we can find them. We don't know them either. But they must have been wonderful people to have produced someone as special as you. Even special people can have such a hard time in their lives that they don't feel they can really take care of a special baby like you. They may have wished for a better life for you and that's why they let us adopt you. Aren't we lucky? I hope you feel you are, too. I just feel sad for them, and imagine you do, too.

Q. Can I ever find my natural mother and father? Will you help me?

A. I certainly will. I would like to know them, too. Of course, I shall be jealous of them, for I want you all to myself. But I know that you must grow up and be on your own. I'm jealous of that, too. So it's not just your real parents. I'm just possessive, because I can care so much about you. When you're ready, let's search together.

And Baby Makes Two: Adoption and the Single Parent

by
Deane Argenta
National Center for Clinical Infant Programs

Daily notes: August 2, 1985

> Seems to be the usual assortment of admissions to the Intensive Care Nursery (ICN). A couple of really tiny babies that will be here for a long time, a few preemies going through drug withdrawal, one baby with fetal alcohol syndrome, and this new little girl, Anna Rosario*. She's full term but only 6 and 1/2 lbs. and her mom is sixteen years old (her second baby). Not a great combination but it could work. So let's see why she's here. Spina bifida and sepsis. The prognosis is not good. I'll need to see this family soon, right after I confer with the doctor and social worker. She sure is a cute baby. Wonder when they've scheduled her for surgery?

This was how I first came to meet my soon-to-be-adopted daughter. She was another admission to the Intensive Care Nursery (ICN). I was the Child Development Specialist for a High-Risk Infant Follow-up Program at a large inner city hospital. We had hundreds of admissions to the ICN and Intermediate nurseries each year and a rather extensive staff to work with the infants and their families in an effort to promote the best possible outcomes.

During the next 3 and 1/2 months Anna recovered from the sepsis, had surgery to close the hole in her spine, and then developed necrotizing enterocolitis (NEC)which required removal of three pieces of her intestine and the creation of a colostomy. While all of this was happening, the hospital staff was attempting to get the family actively involved with their baby and have them learn the procedures that would be necessary to care for her properly when she went home. Unfortunately, after repeated attempts and changes in approach, the staff concluded that the parents had not bonded with their infant and were not able to accept and provide for her special needs. The case was referred to the Division of Youth and Family Services (DYFS), and a statewide search ensued to find a foster family for Anna.

I became more involved with Anna's care as she became medically stable and ready for developmentally appropriate stimulation. After consulting with the medical staff and the physical therapist, I began providing her physical therapy exercises in our general stimulation session three times a day, much as her parents might have. I often "filled in" when parents were not able to visit their baby on a regular basis; it was not uncommon for the nursing staff or myself to provide toys and clothing for babies as they outgrew

FAITH BOWLUS

the newborn nursery supplies or if the parents were not providing necessary items.

One of the greatest frustrations I experienced on this job was having to watch babies grow up in the hospital setting when they could have been medically discharged weeks before. There just weren't enough foster homes available to care for these "boarder babies." How I've grown to hate that term!

DYFS was working hard to find Anna a home but came up empty-handed week after week. While listening to the social worker report in one of our staff meetings that no family had been found yet for the Rosario baby, I began to wonder: Would DYFS consider placing her with me? Months earlier I had applied to DYFS to adopt an infant, but my application had been rejected because I was not married. They didn't say I couldn't be a foster parent, though. I certainly knew how to provide for Anna's health needs. When the staff meeting ended, I contacted the caseworker and made my suggestion. She made an appointment to meet with me and inspect my home later that week.

I'll never forget the day the caseworker informed me that I had been accepted as Anna's foster mother. I went back to the nursery and stared through the window in disbelief. This gorgeous little baby was going to be mine—at least for a while. I went in to hold her and all of my professional distance just melted away. I'd never felt anything like it before. Over the next few weeks, we worked out the details of Anna's placement with me, I bought baby equipment, Anna had one more surgery to close her colostomy, and I started calling relatives and friends to announce the arrival of a new member in our family.

My family was generally supportive and not too surprised, as I had been talking about my desire to adopt for quite some time. They did express concerns about my ability to juggle the demands of a career and a baby with special needs. The doctors still weren't sure of the neurological involvement from Anna's spina bifida or how her abdominal surgeries would affect her

* *The child's name has been changed for this article.*

digestion and growth. The future seemed a little uncertain to me, too. The overriding concern expressed by all of my family and friends was how I would deal with having to give Anna up if she went back to her parents. I decided I would just take each day as it came and enjoy being with Anna for as long as I could.

Three-month-old Anna had never been outside of the hospital nursery until the evening I took her home. Her eyes opened wide when we stepped out into the cold November air, as if to take in as much of the world as possible.

Anna had never been outside of the hospital nursery until the evening I took her home. Her eyes opened wide when we stepped out into the cold November air, as if to take in as much of the world as possible. I shivered as I realized this was the start of a major undertaking. Could I really do this?

I scheduled a ten-day leave from work so that we could get on our own schedule and get to know each other outside of the hospital. It was wonderful—but I could have done without the 3 a.m. feedings.

Anna had been denied admission to an infant day care center because of her previous medical problems (I have since learned not to tell any more than is necessary about her medical history). This really angered me because by this time she had no medical needs requiring special care and she definitely functioned within the normal range.

I located a family day care provider near our home who seemed to be competent. The DYFS caseworker inspected her home also. The provider was approved, and I went back to work, already missing the time I wasn't going to be spending with Anna. This care arrangement lasted about three weeks and then fell apart. One evening I found Anna propped in front of the care provider's television in the same diaper she had been wearing when I dropped her off in the morning. I was livid! Upon further inquiry, I found that Anna had not been fed since 10 a.m. because the provider had been busy trying to paper train her new puppy and she had "forgotten". This provider had presented herself so well when I was interviewing her and during the first three weeks of providing care that it was hard to believe her incompetence. With the caseworker's assistance, we were able to locate a space in an infant day care center, and I went back to work. We had weathered the first storm.

Nothing could have prepared me for what came next. Anna's health took a turn for the worse. She developed chronic pulmonary disease that had me rushing her to the emergency room as she gasped for air. Over the next year and a half Anna was admitted to the hospital 14 times for asthma, infections, pneumonia, and collapsed lungs. She also had three more surgeries. Luckily, foster children in our state are provided with Medicaid health insurance. Anna's hospital bills were astronomical, and her medication and treatments at home often went as high as $300/month. Somehow we both survived all of this and even prospered.

During the 4 and 1/2 years that Anna and I have been together, there has only been one visitation with her biological mother, M. During the first ten months of Anna's placement with me, neither of her biological parents requested to see her or even inquired of DYFS as to how she was.

However, Anna's DYFS caseworker ran into M one day in the hallway of the DYFS offices. M had come with one of her friends to visit that friend's children, who were also in foster care. M did not request a visitation at that time, but the caseworker asked her if she wanted to have Anna baptized (Anna's religion was listed as Catholic on her birth certificate, and I had asked if I should have her baptized). A heated conversation ensued regarding " whose child Anna was" and what type of care she should be receiving. The caseworker informed M that if she wanted to be Anna's mother she would have to start taking on the responsibilities of parenthood, including supervised visitations with Anna and attendance at parenting classes. A visitation was scheduled for the next week.

During the first ten months of Anna's placement with me, neither of her biological parents requested to see her or even inquired of DYFS as to how she was.

I took Anna to the DYFS offices for the visit, spoke with M for a minute or two and then left Anna with the caseworker and M. I went out for a walk during the visit because I could not stand to listen to Anna's crying (she was 10 months old and experiencing separation anxiety). When I returned 45 minutes later, M had already left. Anna was sobbing quietly in the caseworker's arms. Anna needed 20 minutes of holding and consoling from me before she quieted down. I asked what had happened during the visit and was told that it was "confidential." I took Anna to her daycare center for the afternoon and very reluctantly returned to work, feeling exhausted and completely out of control of the situation.

An hour later, a daycare center staff member called and told me to pick Anna up because she was inconsolable and being physically aggressive towards the other babies (a complete change in behavior for her). Anna continued her aggressive behavior, even striking out at me. The staff and I were both very concerned.

I called the psychologist who had done developmental testing on Anna a few weeks before and asked her for assistance helping Anna regain her feeling of security. The psychologist promised to speak with the caseworker to try to gain an understanding of what actually happened during the visitation. For the next three weeks, Anna would wake up screaming two or three times every night and require a considerable amount

of consoling before she was able to fall back to sleep. It is still a mystery to me as to what could have happened during a supervised visitation that would bring about such a dramatic change in Anna's behavior. Even more mystifying is the fact that another visitation was scheduled between Anna and M for two weeks later.

I was told that M had the legal right to see her child even if the experience was upsetting to the child ... The protective services system gave Anna's "rights" less priority than those of her biological parent. As Anna's foster mother, I had no rights at all.

I pleaded with the DYFS caseworker supervisor for the district to intervene and forbid this visit. I was politely told that M had the legal right to see her child even if the experience was upsetting to the child. I then went back to the psychologist, who wrote a letter based on her observations of how traumatic the experience had been for Anna. Once again, the protective services system gave Anna's "rights " less priority than those of her biological parent. As Anna's foster mother, I had no rights at all.

On the day of the scheduled visitation I arranged to take the entire day off in anticipation of another traumatic experience. Luckily, the trauma did not occur because M did not show up for the visit or for any subsequent visit. Neither did she attend any parenting classes.

Based on the caseworker's report of the first visit, the psychologist's letter, and M's lack of participation in the plan that she had agreed to with the DYFS caseworker, a recommendation was made to terminate the legal rights of the biological parents. Anna was now eighteen months old. This recommendation was made by a review board and sent to the family court. The judge agreed with this recommendation and ordered DYFS to begin the process to sever parental rights. I thought we were on our way, and began to believe that Anna and I might become a permanent family. How naive I was!

When Anna was two years old, we moved to a different district in the state. Anna's case was transferred to this district and sent to the adoption resource center, a specialized unit of DYFS that handled the cases of children who were legally free or nearly free for adoption. I was informed by the new caseworker assigned to Anna's case that there were no records on file of DYFS' attempts to notify the biological parents of the court's recommendation to sever their legal rights to Anna. This meant that we had to begin this part of the process again.

After considerable effort, DYFS made contact with both biological parents, each of whom had moved without notifying the Department. Both biological parents decided to contest the adoption, and court dates were set to hear their points of view. I couldn't believe it; after nearly four years without showing any real interest in their child, they wanted her back.

I was overcome by the fear of losing Anna. I contacted a lawyer to see what my rights were. I found, once again, that I had no legal rights at all. I must admit that taking Anna into hiding sounded pretty good at this point.

My only hope rested with the law guardian who had been appointed to represent Anna's rights in these proceedings. It was beyond my comprehension how anyone could look at this case and say that it was not in Anna's best interest to remain with me. After I took Anna to meet with the law guardian, I felt more confident that things would work out.

As things turned out, M neither arrived at court at the appointed time nor notified her lawyer that she could not make the appointment. The judge determined that M had not shown enough interest in Anna and terminated M's legal rights to Anna. But much tc my dismay, Anna's biological father *did* appear in court to file his petition. The judge set another date to meet with Anna's father but warned him that he had better be able to explain where he had been the last four years and why he had never attempted to see his daughter.

As Anna's foster mother I was given the first option of adopting her ... But what happened to the policy that people who are not married are not capable of providing what an infant needs?

After another month of agonized waiting, much to my relief Anna's father did not appear in court at the next scheduled date. His lawyer had not been able to locate him since the last court appearance. Parental rights were severed again, and the way for adoption was cleared.

As Anna's foster mother, I was given the first option of adopting her. Did I want to make ours a permanent relationship? *Were they kidding?* But what happened to the policy that people who are not married are not capable of providing what an infant needs? Anna was no longer an infant. As an older child of minority ancestry who had special medical needs, she was in the "hard-to-place" category. The former policy no longer applied. In addition, DYFS had another policy that children who were secure in their foster family should not be disrupted if at all possible. I find these policies inconsistent and disturbing. Why was I acceptable as a foster parent for an infant but not as an adoptive parent? If a single person is not capable of providing for the needs of an infant as an adoptive parent how can he or she provide adequate care for an older child that may have been in a number of foster care placements and/or have special needs? The policies seem to be saying that "hard-to-place" children don't need, or don't deserve, adequate parenting.

Anna is 4 and 1/2 years old now and enjoys life with great enthusiasm. She has learned to deal with the

restrictions of having a chronic illness but hasn't let it slow her down. She's an exceptionally bright and talented child. I should know; I'm her mother!

Being psychologically pregnant for five years has been an emotional roller coaster . . . I just want this process to be completed . . . Meanwhile, M has given birth to another baby, and I have been asked informally if I would like to be contacted should this child come into the foster care system . . .

Coming to terms with her adoption has not been as easy a process for her as dealing with her illnesses has been. I have always talked to her about how happy I am that she and I are adopting each other (I want her to feel that adoption is something we do together and not something being done *to* her) and that adoption is just one way that families are made. As she grows and matures the words and concepts surrounding adoption seem to have more meaning for her and she re-examines the issues periodically.

When she was three years old we had one particularly in-depth conversation on the subject. It was Christmas night, we had spent a long day with the extended family, and we were now lying on the bed together talking about the day's events before she went to sleep. One of my brothers and his wife had just had their first baby, and Anna had been totally enthralled by the infant. Anna was asking questions regarding how babies grow inside their mothers and trying to relate the process to her own experience. When she came to the point of whose uterus she had grown in, we hit a glitch. She had been reciting to others for some time now that she had not grown inside of me, so I thought she understood this. But now she was sure she *had* grown inside of me. We discussed some more the details of how she had grown inside of M and how she and I came to be together. She accepted my explanation of why her parents couldn't care for her (they were too young and didn't know how to take care of a baby, hadn't finished school and couldn't get good jobs, and didn't have enough money to buy all of the things that children need—food, clothing, housing, medicine), but I anticipate that their actions will continue to be difficult for her to understand as she gets older. Anna's final comment before falling asleep that night was that if someone had just loved her other mother none of this would have happened.

Anna's present fantasies include her going back, growing inside of me, and having me give birth to her. She also believes that someday her father will bring her to school like her friends' fathers do.

I've worked with Anna's teachers whenever possible to help them understand our family situation and our feelings about it, but some of the more subtle comments that have been made, however well intended, show that there is more work to be done. Anna and I are particularly sensitive to the comment that she is "so lucky to have a mother that loves her." Anna asks me why she has to be lucky for me to love her when everyone else's mother just plain loves them. She also wants to know if luck lasts forever. What can I tell her, except that I will always love her and that there is no luck involved?

Our experiences with the foster care and adoption systems have been typical in many respects and relatively unusual in others. I have had to deal with overloaded caseworkers who have not always made home visits on a regular basis, mixed-up or missing paper work, changes in caseworkers without notice, and an extremely slow-moving legal system that seems to protect the rights of the biological parents but not the best interests of the child. The frustrations and anxieties associated with confusing or contradictory responses from the state and the incredible hassles associated with the Medicaid system have at times been overwhelming. This adoption would not be possible for us without Medicaid insurance, but locating medical providers who accept Medicaid and who provide high quality services is a formidable task. My private health insurance company will not cover Anna until the adoption is finalized; even this policy may exclude all of her "previous conditions" from coverage.

On the other hand, we have been more fortunate than most people who have encountered the foster/adoption systems. Anna has been in only one foster care placement in her life and has known only me as her mother. She has had the love and support of a large extended family, and a parent who was able to advocate for her medical needs and navigate the state and federal systems set up to "protect" children.

For me, being psychologically pregnant for five years has been an emotional roller coaster. I feel as if I've been in labor for about three years. I just want this whole process to be completed.

People ask me if I would do it again. I honestly can not say. M has given birth to another baby in the last year and she has physical custody of the child. DYFS is already providing supervision for M and this child, and I have been informally asked if I would like to be contacted should this child come into the foster care system. Anna and I would like to add more children to our family, and I would have a difficult time explaining to Anna why we didn't adopt her sibling if we had the opportunity. But I'm not sure I could survive another ride on this roller coaster.

The "Psychological Work of Pregnancy" in Adoption

by
Anne Williams, BSN, MEd
Infant Mental Health Specialist, West Rockport, Maine

Bringing a child into a family raises many emotional issues for new parents. As they face major changes in their lives, adoptive couples and pregnant couples alike experience powerful—and often similar—feelings. Both adoptive and pregnant couples are likely to progress through distinct stages of psychological development as they prepare for parenthood. One purpose of this article is to explore these feelings and to illustrate the similarities between adoption and pregnancy, making use of stages of psychological development identified by Michael Trout (1987). A second purpose is to suggest ways in which counselors can assist adoptive parents and birthparents in the psychological work they need to do to foster the mental health of adopted infants.

What does it mean to bring a child into a family unit? One thing it always means is change. Some families believe that they have no control over change in their lives—changes are "meant to be." Others feel that life is a process and that it is the overall process, not single events, that is important. Some people resist change, others welcome it, and still others seek constant change, resisting order and stability. Change can be seen as crisis or opportunity. The ability of an individual, a couple or a family to deal with change will be influenced by how quickly the change occurs.

The recognition that powerful, turbulent and often conflicting feelings are a normal and predictable part of pregnancy has been a cornerstone of infant/family theory and practice. Perhaps this article will help those who are immersed in the process of adoption to see that their feelings, too, are indicators of normal stages of psychological development.

Raging ambivalence

The first stage of the psychological development of parents identified by Trout is that of "raging ambivalence." This stage involves a normal questioning of the decision to change a family's familiar and often comfortable equilibrium through the addition of an infant. People will offer a variety of explanations for their positive feelings toward having a child. A teenager may want someone to love. A world class athlete may want to recreate a genetic strength. One person will see offspring as hope for the future. Another will see a baby as an opportunity to repair the past. The ambivalence seen at this stage reflects the conflict associated with giving up the familiar.

Most couples who resolve their ambivalence by deciding to have a child assume that after a few months of "trying" a pregnancy will occur. Some couples share their thoughts with close friends, while others remain private about their decision. Some couples discuss giving up birth control at length; others skirt the issue; some may avoid discussing their feelings entirely.

What happens if no pregnancy ensues and the couple seeks medical advice and assistance? During the process of a fertility work-up, ambivalence surrounding "baby-making" persists, but changes. The couple share with total strangers their once private decision to create a life. They must make multiple decisions about modes of treatment. They make love at designated times, which are discussed with their health care provider.

It is important for the health care provider to consider how this sharing may influence a couple's ambivalent feelings. Listening to their thoughts and anxieties about the desired child, the pregnancy and the fertility treatments themselves will help a couple to explore their ambivalence and to see it as a normal part of deciding to become parents.

Both adoptive and pregnant couples are likely to progress through distinct stages of psychological development as they prepare for parenthood.

During a pregnancy, expectant parents typically face and resolve their ambivalent feelings as the fetus grows and the prospect of parenting becomes real. Monthly appointments with the health care provider help to confirm this reality as the pregnancy is confirmed, the fetus grows, the heartbeat is heard, and the mother's changing shape reveals the baby's growth.

Fertility work also involves monthly appointments with a health care provider. But if medical interventions aimed at resolving the problems of infertility are unsuccessful, ambivalence can be perpetuated rather than resolved. The couple's feelings of doubt and self-deprecation may increase, yet there is hope that pregnancy will occur in the next monthly cycle. A pregnant couple may feel ambivalent about their desire to depart from their current, familiar lifestyle. An infertile couple is faced with many choices—of treatment, of ways to adopt, or of giving up altogether the idea of having a child. One couple expressed their ambivalence about interventions designed to bring about a pregnancy by questioning the wisdom of "fooling with mother nature."

Because fertility work tends to focus on pregnancy as an outcome of treatment, couples may not be given an opportunity to grapple with their ambivalent feelings about the child who will be the outcome of the pregnancy. Unless the couple can discuss not only the expected impact of a pregnancy on their relationship and lifestyle but also the effects of bringing a child into their family, the stage of raging ambivalence may be perpetuated.

The process of adoption also involves ambivalence. A couple who decide to adopt a child may initially feel great relief: they have given up fertility work, with its focus on pregnancy, and have decided to work toward adoption. It is helpful for counselors to ask couples what

circumstances led them to change their focus. It may be that a child was offered to them, or that a definitive diagnosis of infertility encouraged them to consider adoption.

The decision to adopt allows the process to begin, but ambivalence remains as the couple learn about adoption and wonder how they will proceed. With "open" adoption becoming more common and birthparents becoming involved in the placement of their children, the adoptive couple may question their ability to "share" their child with the birth family. (Although it is unusual for a child to be parented by both birth and adoptive parents, more and more birthparents are interested in maintaining some level of communication with their child's adoptive family.) The process raises ambivalence about the adoptive couple's own identity.

A "miscarriage" may occur in the adoptive process. This may be a physical miscarriage or a change of heart on the part of the birthparent or adoptive parent.

When told of a child whose birth mother wanted her to be adopted into a Baptist family and of another whose parents wanted their child adopted into an Hispanic family, an adoptive mother-to-be said to her case-worker, "We've just become an Hispanic Baptist family!"

Ambivalence may also be perpetuated by "miscarriages" in the adoptive process. This may be a physical miscarriage or a change of heart on the part of the birthparent or adoptive parent. Adoptive parents fears about birthparents' changing their minds can also perpetuate ambivalence. When counseling is not part of the adoption process—as is often the case in privately arranged adoptions—changes of heart are more common.

The costs involved in the adoption process may also contribute to a couple's inability to resolve ambivalent feelings. Health insurance does not pay for legal or adoption agency fees. Parents may find themselves struggling with the fact that they have to decide how much money they intend to spend on the adoption. One family tells of spending $25 thirty years ago. It is common to spend from $7,000-$30,000 today. Higher costs involved in adopting Caucasian children may add to the feelings of ambivalence of Caucasian couples, as would-be parents compare the costs of adopting a child with their own racial background with the costs of adopting a child with a different ethnic heritage.

Having to describe the desired child to adoption workers also brings new issues to the adoptive couple's awareness. With some feeling, one would-be adoptive mother compared adopting a child to buying a used car (considering color, age, location and trustworthiness of past owner). Given the availability for adoption of children of mixed race and children with disabilities, the process of describing characteristics of a desired child may provide a couple with an important opportunity to explore their ambivalence about their capacities as parents as well as their feelings about children with special needs. This opportunity to discuss their feelings also gives them a chance to consider their fantasies about their desired child and to grieve the loss of their hoped-for biological child.

The ages of birthparents and adoptive parents may fuel ambivalent feelings. Some couples in their late thirties and forties may believe—or be informed by agencies—that they are too old to adopt. Thus a decision may be made "for" them, but such a decision does not help them to explore their ambivalence. The adoptive family may be making the decision to bring a child into their lives at a time when the children of other couples their age are leaving home; their potential isolation from their own peer group may be worrisome. When birthparents are adolescents, their age may be an issue for the adoptive parents, who may be concerned about prenatal risks to the infant as well as about teenagers' possible struggles with the commitment to place their child for adoption or confusion about the differences between foster care and adoption.

How can counselors help adoptive parents progress through this stage of ambivalence? Allowing them genuinely to explore their feelings is key to this work. The theory of Re-evaluation Counseling (Personal Counselors, Inc., 1982) suggests that voicing a statement that contradicts an individual's unspoken feelings will lead to a behavioral discharge of feeling. The counselor can then encourage further expression and exploration of feeling.

"Contradiction technique" offers some useful approaches to eliciting the expression of emotions that have undoubtedly been accumulating. For example, ask a couple who are involved in fertility work to say, with absolute conviction, "We've made the decision *not* to have a baby!" Or encourage a woman to say, with joy in her voice, "I'm pregnant!" These directives will contradict the ambivalence sufficiently to promote the release of feelings through tears, expressions of rage, laughter, yawning, compulsive talking, or trembling. The counselor's readiness for whatever behaviors emerge (and ability to postpone the expression of his or her own emotions) creates an atmosphere that encourages clients to let their feelings flow.

Narcissism/investment in self

The second stage of the normal psychological work of pregnancy involves a need to nurture oneself. Patterns of self-nurturing are established very early. When young children experiencing change seek support from familiar territory, people, routines, or objects, we see their behavior as normal, necessary and healthy. In adults, this return to old patterns is termed "regression," but regression is a healthy mechanism of defense during times of change.

At this stage, the pregnant woman may care for herself and her unborn child by taking naps, eating extra meals, asking for help with domestic chores, and seeking more attention from her spouse. Her interest in her profession may wane. The process of fertility treat-

DAVID GLADSTONE

ments may elicit similar signs of narcissism. On the other hand, the diagnosis of infertility may create feelings of unworthiness that interfere with would-be parents' natural desire to take care of themselves.

For parents awaiting adoption, like those experiencing pregnancy, this stage may manifest itself in a variety of ways. For example, one adoptive mother described buying herself many new clothes during this time. Another woman invested in weekly massages and created special times to be with other women. One couple talked of a vacation as their "last trip together as two." Another couple asked that large group celebrations be saved for the future, as they wanted time to themselves to consider the changes that were taking place. But they added, "Go ahead and make the quilt, and give us diapers!" They had left ambivalence behind and were able to ask for what they needed.

The quality of a couple's relationship and the amount of time they have been together may influence their capacity to be narcissistic. A couple who had been together for 20 years wondered how the introduction of a child would change their relationship. The woman was concerned about her ability to nurture herself, her spouse and the child, as well as about the effect of leaving her job to stay at home. The man wondered how he would be able to do the same, as well as provide for the family financially. The couple explored their ability to nurture themselves freely and without guilt, learning, in the process, about each other as individuals who could be separated from the patterns of their longstanding relationship.

Examining issues of narcissism and investment in the self not only assists prospective parents in their psychological work at this stage, but also influences their ability to care for themselves after the arrival of their child. The counselor's understanding of and "giving permission to" the need for investment of energy in oneself will promote the couple's development. Asking how they are caring for themselves and what things are new and exciting in their lives is a good starting point. To discourage intellectualizing and elicit feelings, one can ask the client to say, with pride, "I am the most important person, and I show myself this by ...." This may bring on yawns and giggles at first. If it does, have the client repeat the statement, with the intention of eliciting further expression of feelings.

It is important to note that the normal psychological work of this stage will happen at different times and in different ways. A balance of narcissistic energy in a dyad is necessary for the relationship to continue to grow in a positive direction. As the balance will shift from partner to partner and from stage to stage, the work of a counselor is to listen carefully to each person, encourage expression of feelings, and help each partner (and the couple) determine where to focus their energy.

The baby as separate

The stage of identifying the baby symbolically as separate from themselves initiates the integration of the baby into the parents' lives. This stage also provides an opportunity for parents to define their "fantasy

baby," to whom they must say good-bye when they meet their real child. A pregnant couple may talk to the unborn child about their lives, perhaps describing important places or events. They may begin to notice the unborn baby's responses to environmental stimuli. They decorate the baby's room and talk about names for the baby. If they know the baby's sex, they may consider aspects of maleness or femaleness in their child. They are allowing themselves to emerge from the self-centered stage and are looking at the reality of another being entering their lives.

When adoptive parents are asked what type of child they would like, they realize they have choices. They consider all children. This process is very different from the thoughts and fantasies they experienced during their fertility work.

For adoptive parents, this stage has similar meanings. However, the amount of time a couple has to prepare for the coming of their baby is unlikely to be that of the normal preganacy. Some adoptive couples are given only 24-hours notice that their baby is ready for them. Others wait for years. Still others may be involved with the birthparents, who share many of their fantasies about their child. These adoptive parents may have experiences similar to those of this stage of pregnancy—they begin to prepare the baby's room, they talk of names, and they share their feelings with the birth-parents as well as their family and friends.

Other aspects of this stage are unique to the adoption process. For example, adoptive parents are asked what type of child they would like. Their initial reaction may be that they would like a child like themselves (i.e., their biological child), but they realize they have choices. They consider all children. They look at children differently, as if they are "shopping" for a child. They ask themselves, "Would *this* child fit in my family?" or "How would I parent *that* child?" or "What would the adoption of a special needs child be like for me, my family and my community?" This process is very different from the thoughts and fantasies they experienced during their fertility work. The genetic pool has been broadened, and the parents are being asked to define their preferences. They also begin to "market" themselves as parents, working on their home study (involving writing an autobiography, physical examinations, home visits by caseworkers, character references, adoption classes, and police checks), writing a "Dear Birthparent" letter, and considering their philosophies of parenting with their caseworker. This work helps adoptive parents to begin thinking about the child as an individual and themselves as this child's parents.

Parents who have doubts about bringing a child into their lives or about the adoption itself, as well as parents with personal insecurities, may avoid some aspect of preparing for the baby's arrival. The disappointments of fertility work may result in feelings of unworthiness; some parents may feel that they do not deserve to have a baby. They may not share their plans to adopt or may delay setting up the crib until the arrival of the baby. Insecurity may also be an issue for adoptive parents because they do not have the certainty of the pregnancy confirming the baby's existence. This doubt may be decreased when there is a trusting relationship with the birthparents or when the adoption agency tells a couple how long they will have to wait for their child.

In an adoption plan that includes communication between adoptive and birthparents, the birthparents' own needs may encourage the adoptive family to advance through this stage. The birthparents are seeing the baby as "separate" and are starting their work of saying good-bye. They need the adoptive family to create the baby's space; they are looking for concrete evidence, from pictures of the baby's room to discussions about how the baby will be integrated into the adoptive family, that their baby has a "place" in its new home. The birthparents' ability to share genetic information, family history, and even idiosyncracies with the adoptive family helps to strengthen the adoptive parents' knowledge of their baby's separate identity.

Counselors may need to help parents identify with their baby as separate. Asking parents to describe their baby or to write their baby a letter will help. For couples who have undergone unsuccessful fertility work, saying "I'm a Mom," or "I'm a Dad," may help them identify with their feelings. For those who have underlying feelings of unworthiness, this exercise provides a contradiction to their belief that they "cannot" be a parent. It may also be useful to ask parents to say, "My baby is a girl/boy, and this means to me ....." If adoptive parents-to-be have a picture of their child, explore with them how they think the child is feeling, where the child is living, their eagerness to be with the child, and their frustrations about the "red tape," especially in foreign adoptions.

Integrating expectations

When the baby arrives, a time of adjustment begins, a time of processing the reality of the situation. Previous psychological stages may reoccur. The couple may face their ambivalence again as the reality of their situation hits them. They may feel the need for self-nurturing and welcome the arrival of casseroles and help with housework. They may seek solitude as their way of integrating the changes that are taking place. Whatever their choice of action, the couple are attempting to replace their fantasy with reality. This integration of their expectations with the real child is a necessary part of the bonding process.

Knowledge of the biological background of the child gives adoptive parents a head start in this work. They have imagined certain physical characterisitics of the child, and upon meeting the child will confirm these

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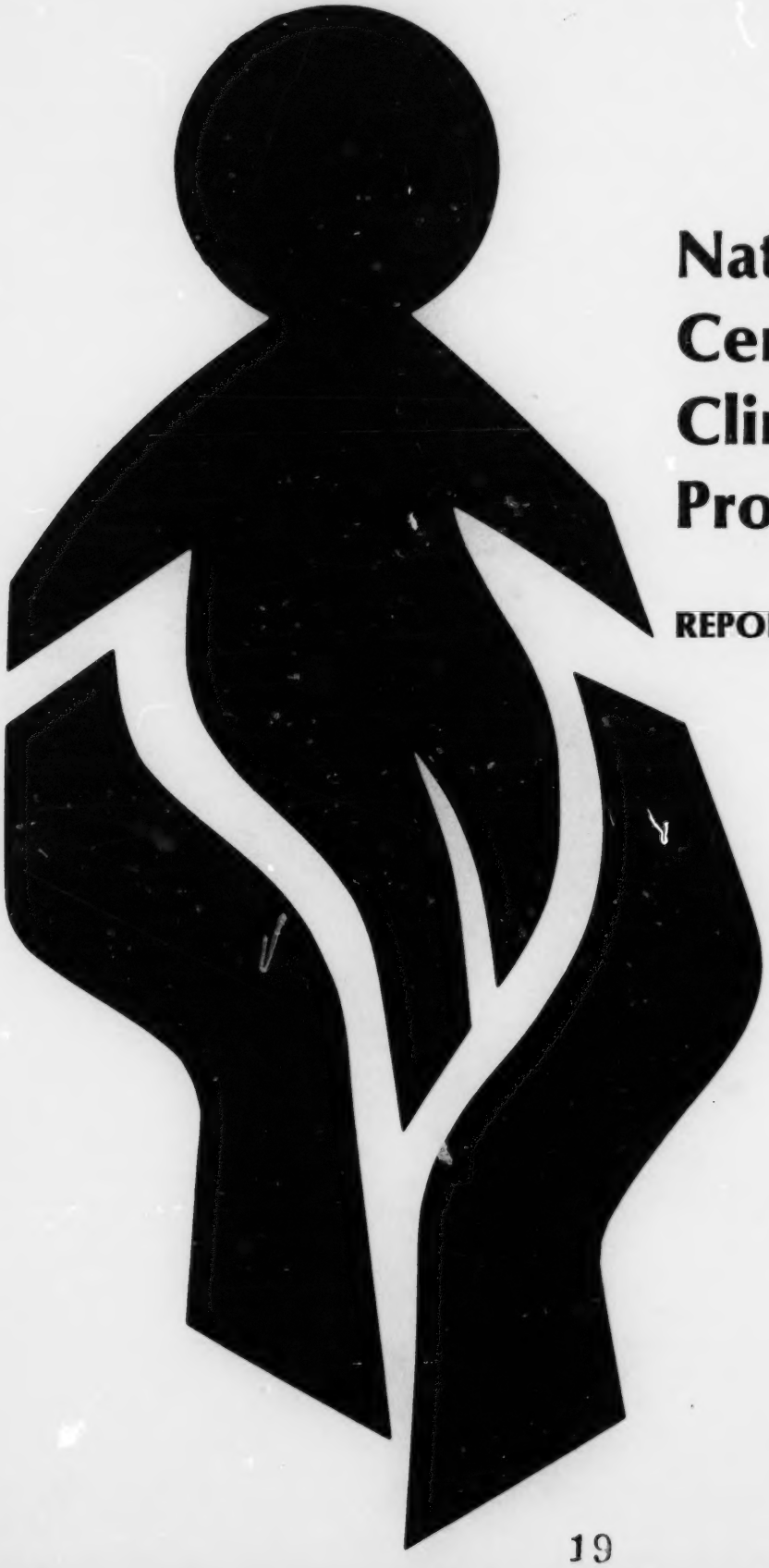

National Center for Clinical Infant Programs

REPORT 1989

The National Center for Clinical Infant Programs is a non-profit, tax-exempt corporation. It was established in 1977 by outstanding representatives from the fields of mental health, pediatrics, child development, and related fields, as well as community leaders. The National Center's goal is to improve and support policies and practices that will facilitate optimal health, mental health and development of children and families in the earliest years of life.

The National Center for Clinical Infant Programs is an association of leaders in child, family and community development with representatives from the fields of mental health, pediatrics, nursing, occupational therapy, psychology, psychiatry, human development, social work, education, special education, business and philanthropy. Administrative activities are undertaken by the staff of the National Center at the direction of the Board. Program activities are carried out by staff in collaboration and consultation with Board members, other individuals and organizations.

Offices for the National Center for Clinical Infant Programs are located at 2000 14th Street North, Suite 380, Arlington, VA 22201, tel: (703) 528-4300, fax (203) 528-6848.

Clinical

Preventive intervention, diagnosis, treatment. Clinical intervention takes place in a variety of settings such as hospitals, doctors' offices, child development centers. A clinical approach looks at an infant's individual strengths and vulnerabilities. It is based on two assumptions: 1) that human growth involves multiple, interrelated lines of development including emotional, cognitive and physical; and 2) that an infant must be viewed in a context which includes not only his own development, but also parents, other family members and the larger social environment.

Infant

We define, perhaps somewhat arbitrarily, infancy as the period from before birth to age 3.

Eleanor Stokes Szanton, *Executive Director*
Carol Berman, *Associate Director*
Emily Schrag Fenichel, *Associate Director*
David Chavkin, *Senior Program Associate*
Peggy Pizzo, *Senior Program Associate*

Other program and administrative staff:

Penny Anderson*
Deane Argenta
Elaine Artis
Patricia Biro
Joan Delcoco
Linda Eggbeer
Pat Guwang
Judy McLean
Regina Obey
Thelma Orlofsky
D. Gwen Phillips
Nancy Scull
Gail Hawkins-Shirar

* Left staff during 1989

From the President

As one of the people who founded the National Center for Clinical Infant Programs in 1977, I am honored to be serving as president of this flourishing, effective organization.

The National Center was created by a small group of individuals from a range of disciplines and backgrounds. In our work with infants and new families, we had been touched by the excitement and energy we saw in both parents and children, but also impressed by the vulnerability of the earliest years. We wanted to take advantage of opportunities for learning about families with infants, and for strengthening them.

NCCIP was formed to help individuals and organizations join together in that effort. It has flourished because of the combined efforts of programs all over the country, because of individuals who have volunteered their efforts, and because of public and private sector support. The National Center now serves as a resource for thousands of practitioners, parents, administrators, researchers, journalists and policymakers in this country and abroad.

As we enter the 1990's, we see both opportunities and challenges ahead—for babies and families in this country and for those who would offer them the timely support they need. We know a great deal about the energy available in parents and in developing infants, and we are learning how to capture and strengthen it through policies and practice approaches. We know a great deal now that we can and must put to use. We recognize that much remains to be learned, and commit ourselves to continued and increased collaboration among parents, practitioners, researchers, teachers, policymakers, theoreticians, and administrators. Infants, toddlers and their families need and deserve the best we can offer.

T. Berry Brazelton, M.D.
President

From the Executive Director

In 1989, the National Center for Clinical Infant Programs continued to expand its scope and its staff. We have found increasing interest in and support for our multidisciplinary initiatives concerning family-centered services to infants with disabilities or special health care needs; the quality of infant/toddler child care; the training of practitioners to work with children from birth to three and their families; and our advocacy for services for infants and toddlers.

The following pages describe a rich array of recent accomplishments and ongoing activities of the National Center for Clinical Infant Programs. These all have a common goal—strengthening the development of children and families in the earliest years of life.

We welcome the ideas, support and participation of all who share our concerns. They are essential to our ability to continue and increase our work in this critical area.

Eleanor Stokes Szanton
Executive Director

Activities of the National Center for Clinical Infant Programs

We are infants only once. The experiences of our earliest days, weeks and months lay a foundation for the rest of our lives. They shape the lives of future generations as well.

Families of infants and toddlers need, as never before, responsive, skilled support as they rear children in our complex society. Whether families are coping with the "ordinary" stresses of balancing work and family or are facing the challenges posed by special health care needs, poverty, or cultural transition, parents and the professionals who work with them need support for their collaboration.

The National Center for Clinical Infant Programs works to:

- Expand the awareness of the importance of the earliest years of life for human development;
- Translate research into policy and practice;
- Nurture new leadership; and
- Enable others to work more effectively on behalf of infants, toddlers and their families.

NCCIP acts as a source and disseminator of knowledge; as a consciousness raiser; as a support center; and as a catalyst. The National Center carries out these roles in three major contexts:

- Promoting professional excellence in services to infants, toddlers and their families;
- Addressing service system issues at the national, state and community level;
- Collaborating in the development of public policy affecting children from 0-3 and their families.

Highlights of NCCIP's recent accomplishments and ongoing activities illustrate our efforts to address quite specific needs and issues, and also the intrinsic interrelatedness of all aspects of our work.

PROMOTING PROFESSIONAL EXCELLENCE IN SERVICES TO INFANTS, TODDLERS AND THEIR FAMILIES

NCCIP works to attract talented and committed people to infant/family practice; to expand and enrich training opportunities; and to serve as a forum for the exchange of ideas and information.

Zero to Three

Zero to Three, the bulletin of the National Center for Clinical Infant Programs, provides reports of innovative research and service programs; essays on conceptual, clinical and public policy issues; case reports; and information on new publications, conferences and training opportunities, government initiatives and funding sources. Published five times per year, *Zero to Three* reaches approximately 7500 practitioners, policymakers, teachers, administrators, researchers and libraries. Issues on special topics, such as group residential care for infants, clinical approaches to drug-exposed infants and their families, and the training of infant/family practitioners, are also disseminated to groups working in these areas.

National Training Institutes

NCCIP's biennial National Training Institutes have become known as occasions for intellectual challenge, sharing of experience and recognition of the continuing growth of the field of infant health, mental health and development. The December, 1989 National Training Institute, entitled "Promises To Keep: Directing Research, Resources and Skilled Personnel To Support Infants, Toddlers and Their Families," continued this tradition.

Almost 1500 attendees participated in the pre-institute seminars, plenary sessions, special interest sessions, and poster and video presentations that have become regular features of NCCIP National Training Institutes.

Innovations in the 1989 program included a press briefing co-sponsored with the Scientists' Institute for Public Information; two-session pre-institute seminars on particularly complex topics; 16 in-depth clinical case presentations; and a special emphasis on training issues in poster and video sessions.

Scholarship funds, available for the first time in 1989, enabled NCCIP to expand the diversity of Institute participants and to assist agencies wishing to send multiple staff members.

Regional Conferences

The National Center has collaborated with organizations and agencies in Illinois, Maine, New Hampshire, New York, Texas and California to provide opportunities for participants to acquire new knowledge of infant development from nationally known experts, to share insights about their work and to begin to form regional networks for further collaboration on behalf of infants, toddlers and their families. In 1989, an eight-organization coalition, including NCCIP, the California Infant Development Association, and six California state agencies, built upon its successful collaboration in 1987 to sponsor a second regional conference in Los Angeles. Four strands addressed health and technology issues; family issues; service delivery; and policy and implementation issues.

NCCIP staff members are increasingly called upon to address meetings of community, state and national organizations on topics reflecting their special expertise and also to provide a national perspective on issues affecting infants, toddlers and their families. The National Center also assists organizers of infant/family-related conferences around the country by suggesting speakers, providing materials, and publicizing events in Zero to Three.

Intensive Courses

Following NCCIP's first intensive four-day course in 1987, planning began for a similar effort in Chicago, Illinois. The planning group included Chicago-based National Center Board members, staff of four state agencies, and representatives from Chicago hospitals, teaching institutions, social service agencies, early intervention programs, and family resource agencies.

The group determined at the outset to plan both an intensive short course and related follow-up activities. "Building Better Services for Multirisk Infants and Families," a three-day course for 60 supervisors and others with training responsibilities, was held in October, 1988. Follow-up meetings in March, 1989 and October, 1989 featured both out-of-state speakers and case presentations by Chicago practitioners. The October event drew 160 participants representing every service delivery system, university, and public agency in the city concerned with children 0-3 and their families.

The National Center Fellowship Program

Established in 1981, the NCCIP Fellowship Program provides enrichment for one or two years for advanced trainees who are committed to teaching, research and the creation of effective models of clinical services for infants, toddlers and their families. The program is multidisciplinary in scope; applicants are sponsored by directors of selected training programs in early childhood education, special education, nursing, pediatrics, psychology, psychiatry, social work, human development, and the developmental therapies.

The eight to sixteen NCCIP Fellows selected each year share aspects of their independent work at a one-week conference hosted by a leading training center; participate in NCCIP scientific meetings and Training Institutes; and use the small stipends provided to help with travel or other expenses associated with their training. Graduate Fellows maintain communication among themselves and with members of the NCCIP Board and staff; they also contribute to NCCIP publications, conferences and work groups.

As of September, 1989, there were 93 current or graduate National Center Fellows. An independent evaluation of the Fellowship Program as it operated from 1981-1988 concluded that the program "made impressive progress toward the goal of developing leaders in the infancy field. A highly talented and heterogeneous group of fellows was recruited ... The fellowship was instrumental, and in many instances decisive, in consolidating identity as an infant specialist and reinforcing commitment to remain in the field."

The Training Approaches to Skills and Knowledge (TASK) Project

A three-year effort that began in January, 1988, the TASK project has sought to address the concerns of four groups with a major stake in training personnel for work with infants, toddlers and their families. These groups include parents, educators, professional organizations and practitioners, and policymakers. Project staff and advisors have created a network of approximately 1,000 individuals who are engaged in some aspect of the training of infant/family practitioners; their activities and concerns are reported in a bi-monthly newsletter, *TASKTalk*. TASK staff and advisors also worked during 1989 to develop a series of publications under the general title, *Preparing Practitioners To Work with Infants, Toddlers and Their Families: Issues and Recommendations*. These documents discuss competence among infant/family practitioners and describe the elements in pre-service, inservice and professional development training that are most likely to foster competence.

The NCCIP Task Force on Diagnostic Classification

A group of National Center Board members and other clinician/researchers has been working since 1984 to develop new diagnostic categories for emotional disorders in infancy and early childhood. The group is paying particular attention to two issues that are not sufficiently addressed by present diagnostic systems: 1) the need to account for individual constitutional differences, which explain some symptoms commonly presented by infants in distress; and 2) the need to attend to aspects of the environment and parental functioning which affect the infant's emotional development and adaptation. Using a common Infant Data Base form, Task Force members and their colleagues are recording and pooling data on the disorders of affect, regulatory disorders, and psychic trauma disorders among the infants and toddlers who are referred to mental health professionals.

Clinical Infant Reports

Clinical Infant Reports is a series of book-length publications of the National Center for Clinical Infant Programs. Each volume in the series addresses an identified gap in the professional literature and relates theoretical concepts to practice issues, often through the use of case material. The fourth volume of Clinical Infant Reports, currently in press, is entitled **Touch: The Foundation of Experience,** edited by Kathryn Barnard and T. Berry Brazelton. *Touch* includes the full text, with, in many cases, additional material, of papers presented by researchers and clinicians who participated in Pediatric Round Table X, sponsored by Johnson & Johnson Baby Products Company.

Reginald S. Lourie Scientific Meetings

Semiannual scientific meetings for National Center Board members, current and graduate Fellows, staff, and invited guests from the federal government and local academic institutions provide opportunities for discussion in an informal setting of new research and clinical issues concerning infants, toddlers and their families. Dialogue between presenters and participants from a broad range of disciplines sharpens the focus of the questions researchers are addressing and brings working hypotheses and preliminary research findings under close but genial scrutiny, following the tradition established by NCCIP's founding chairman, the late Reginald S. Lourie. Recent scientific meetings discussed "The Effects of Prenatal and Postnatal Exposure to the Maternal Voice" and "What Is It in the Intervenor Relationship That Is Corrective?"

ADDRESSING SERVICE SYSTEM ISSUES AT THE NATIONAL, STATE AND COMMUNITY LEVEL

Completion of Project Zero to Three

From 1983-1989, with support from the Bureau of Maternal and Child Health and Resource Development, U.S. Department of Health and Human Services, NCCIP provided technical assistance and served as a forum for information and resource exchange to fifteen states working to develop comprehensive and coordinated early intervention services for infants and toddlers with disabilities and their families. The fifteen states included in this "Project Zero to Three" were: Florida, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, New Jersey, New York, North Carolina, Ohio, Oregon, Texas, Utah, and Washington.

Over the years, Project Zero to Three brought state administrators, parents of young children with disabilities, and nationally recognized experts together to share ideas and successful strategies, and to identify and begin to address unmet needs. The final months of the Project saw increasing attention to the implementation of P.L. 99-457, the Education for the Handicapped Act Amendments of 1986 and a synthesis of parent contributions to the project, particularly in two publications, *The Open Door: Parent Participation in State Policymaking about Children with Special Health Care Needs* and *Four Critical Junctures: Support for Parents of Children with Special Needs.* Other publications from the final year of Project Zero to Three included *The Intent and Spirit of P.L. 99-457: A Sourcebook, Serving Culturally Diverse Families of Infants and Toddlers with Disabilities,* and a revised edition of *Keeping Track: Tracking Systems for High-Risk Infants and Young Children.*

When parents, state liaisons and Core Advisory Panel members were surveyed about their views of Project Zero to Three, they responded that the most successful aspects of the Project were: 1) enabling parents to be better utilized as resources by state agencies and planning bodies; 2) facilitation of national, multidisciplinary networking and knowledge transfer; and 3) fostering a health component in early intervention.

PROMOTING SUCCESS IN ZERO TO THREE SERVICES

In July, 1989, the National Center received a five-year Maternal and Child Health Improvement Project Demonstration Grant from the Bureau of Maternal and Child Health and Resource Development (MCJ-115041). This new endeavor, entitled "Promoting Success in Zero to Three Services: A National Resource Center for Infants and Toddlers with Special Health Care Needs," will promote a national focus on family-centered, community-based coordinated care for young children with special health care needs as one of ten national resource centers for children with special health needs.

NCCIP will function as a national resource center to identify, promote and disseminate information concerning

infants and toddlers with disabilities or at risk of developmental problems, and their families. It will also identify promising community-based approaches that successfully address the connections among prevention, early identification and intervention for infants, toddlers and their families. In 1989 an effort was begun to identify as many as five model communities to participate in a five year effort to promote their promising approaches nationally. The project will give these communities additional opportunities for networking and professional development.

FLORENCE SHARP

National Early Childhood Technical Assistance System (NEC*TAS)

The National Center for Clinical Infant Programs is one of six members of a collaborative system to assist states and other designated governing entities in developing multidisciplinary, coordinated, and comprehensive services for young children with special needs and their families, within the context of P.L. 99-457, the Education for the Handicapped Act Amendments of 1986. NEC*TAS (the National Early Childhood Technical Assistance System) is funded by the Office of Special Education Programs, U.S. Department of Education and coordinated by the Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Since helping to form NEC*TAS in 1987, NCCIP staff have participated in on-site and telephone consultations to states, programs, professionals and parents; planned special meetings on data collection, eligibility issues, and personnel preparation as well as annual "Partnerships for Progress" conferences; and reviewed and disseminated print materials. National Center Board and staff members serve on the NEC*TAS advisory board. NCCIP Board members and staff led a NEC*TAS-supported Task Force that developed and published *Screening and Assessment: Guidelines for Identifying Young Disabled and Developmentally Vulnerable Children and Their Families.*

Better Care for the Babies

The Better Care for the Babies Project is an effort to help states access available expert knowledge and funding in order to improve infant day care. Supported by a two-year grant from the Ford Foundation and the Pittway Corporation Charitable Foundation, the project works with Governors' offices and key administrators from three states to facilitate collaborative planning and information exchange: 1) between project staff and state administrators; 2) among administrators of child health, child care and early intervention services and policy development within each state; and 3) between project states and day care improvement initiatives in other states.

Project staff have begun work with the state governments of Illinois and Utah and will choose the third state in 1990. This work aims to increase the opportunities in each state for: 1) disadvantaged infants and toddlers to participate in immunizations and preventive health care, including developmental assessment and follow-up; and 2) caregivers in infant and toddler child care to participate in training. The focus is on both day care centers and regulated family day care homes. The project will analyze the initiatives as they are developed and carried out within the three states in a case study.

COLLABORATING IN THE DEVELOPMENT OF PUBLIC POLICY AFFECTING CHILDREN FROM 0-3 AND THEIR FAMILIES

Publications

The various publications of the National Center for Clinical Infant Programs offer thoughtful discussion of policy issues affecting infants, toddlers and their families.

Project Zero to Three publications introduced audiences to new voices: parents spoke to policymakers in *The Open Door;* key Congressional staff addressed state administrators, parents, and practitioners in *The Intent and Spirit of P.L. 99-457;* insights from cultural anthropologists, practitioners, and culturally diverse families informed the policy recommendations of *Serving Culturally Diverse Families of Infants and Toddlers with Disabilities.*

Public policy issues such as increasing drug exposure among infants and the growing number of very young children without permanent homes received attention in *Zero to Three.* The *TASKTalk* newsletter provided a forum for discussion of the policy issues associated with training and credentialing infant/family practitioners.

NCCIP's Media Task Force alerted editorial staff of newspapers across the country to emerging concerns about residential group care for infants and toddlers and to health and safety hazards in unregulated child care. The Scientists' Institute for Public Information and NCCIP co-sponsored a briefing for journalists on "Preparing for School Success: The Infant Toddler Years."

National advocacy for infants, toddlers and their families

Since its founding,the National Center for Clinical Infant Programs has become an important "information broker" between the academic, clinical and scientific community and federal policymakers, in both the legislative and executive branches. NCCIP also influences the activities and agendas of other organizations that are concerned generally with the well-being of children and families but lack specific knowledge of the circumstances and needs of the 0-3 population.

JOHN DAVID ARMS

The National Center advocates only for concepts, not for or against specific pieces of legislation. This approach permits us to maintain positive relationships with most congressional and executive agency offices while still communicating our message about the importance of the earliest years of life. In the debate over child care, for example, NCCIP Board members who have been invited to testify before Congress and staff members who have engaged in ongoing dialogue with legislators have advocated for direct financing and strong standards. In groups such as the Ad Hoc Coalition on Child Welfare and the National Coalition on Drug and Alcohol Dependent Women, NCCIP staff have worked to make sure that emerging policies and draft legislation reflect awareness of the complexity of infant-parent relationships and the need for a stable, supportive caregiving environment.

NCCIP contributes to the public policy debate through its ability to analyze and comment. Because staff in many child and family advocacy organizations have multiple responsibilities, they will often embrace well-reasoned analyses and comments on pending legislation or proposed regulations that have been prepared by other groups. We are playing a similar role in analyzing the final regulations of the Education for the Handicapped Act Amendments of 1986.

FINANCIAL STATEMENTS

KELLER, ZANGER, BISSELL & COMPANY
Certified Public Accountants

Independent Auditors' Report

To the Board of Directors
National Center for Clinical
Infant Programs
Washington, D.C.

We have audited the accompanying balance sheet of the National Center for Clinical Infant Programs as of December 31, 1989 and the related statements of revenue and expenditures and changes in fund balances for the year then ended. These financial statements are the responsibility of the National Center for Clinical Infant Programs management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards, governmental auditing standards, and the requirements of the Office of Management and Budget Circular A-110. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly in all material respects, the financial position of the National Center for Clinical Infant Programs as of December 31, 1989 and the results of its operations for the year then ended in conformity with generally accepted accounting principles.

Keller, Zanger, Bissell & Co

Rockville, Maryland
March 29, 1990

BALANCE SHEET
December 31, 1989

ASSETS	Current Funds Unrestricted	Current Funds Restricted	Total All Funds
Current assets:			
Cash - checking	$ 63,686	$ -	$ 63,686
Cash - savings	391,097	391,924	683,021
Accounts receivable	60,500	-	60,500
Grant receivable	78,513	-	78,513
Prepaid expenses	5,443	-	5,443
Total current assets	499,324	391,924	891,253
Property and equipment:			
Furniture and equipment	70,028	-	70,028
Equipment held under capital lease	5,790	-	5,790
Leasehold improvements	1,866	-	1,866
Software	2,939	-	2,939
	82,623	-	82,623
Less accumulated depreciation and amortization (including amortization applicable to equipment acquired under capital lease of $2,606)	44,775	-	44,775
Total property and equipment	37,848	-	37,848
Other assets:			
Refundable deposit	139	-	139
Total assets	$537,311	$391,924	$929,239

See Notes to Financial Statements

LIABILITIES AND FUND BALANCE	Current Funds Unrestricted	Current Funds Restricted	Total All Funds
Current liabilities:			
Current maturities of obligation under capital lease	$ 1,499	$ -	$ 1,499
Accounts payable and accrued expenses	188,853	-	188,853
Payroll taxes withheld and payable	9,949	-	9,949
Accrued vacation	764	-	764
Deferred revenues:			
Grants	-	391,924	391,924
Zero to three subscriptions	12,594	-	12,594
Total current liabilities	213,659	391,924	605,583
Long-term liabilities:			
Obligation under capital lease	3,491	-	3,491
Less current maturities	1,499	-	1,499
Total long-term liabilities	1,992	-	1,992
Total liabilities	215,651	391,924	607,575
Fund balance	321,664	-	321,664
Total liabilities and fund balance	$537,315	$391,924	$929,239

STATEMENT OF REVENUE AND EXPENDITURES
Year Ended December 31, 1989

	Current Funds		Total
	Unrestricted	Restricted	All Funds
Revenue:			
Contributions	$ 247,840	$ 11,182	$ 259,022
"Zero to three" subscriptions	80,067	-	80,067
Grants:			
Government	267,135	-	267,135
Foundations	-	216,907	216,907
Government - subcontract income	101,193	-	101,193
National training institute	187,655	9,068	196,723
Sales of publications and tapes	12,836	-	12,836
Royalties	1,345	-	1,345
Mailing list rental	3,074	-	3,074
Interest	31,823	-	31,823
Staff earned income	2,418	-	2,418
Other	6,855	-	6,855
Total revenue	942,241	237,157	1,179,398
Expenditures:			
Program services:			
Zero to three	28,316	58,333	86,649
Fellowship	64,133	5,440	69,573
1989 Training Institute	113,016	57,250	170,266
Public policy and public education	93,633	-	93,633
Clinical infant report	2,735	-	2,735
Scientific meetings	8,889	-	8,889
Research facilitation	18,968	-	18,968
Regional institute	7,517	-	7,517
Screening and assessment	15,328	-	15,328
CASSP	1,118	808	1,926
MCH - promoting success in zero to three	63,435	-	63,435
Media task force	8,721	-	8,721
Foster care for the babies	-	33,584	33,584
NEC * TAS	76,744	-	76,744
TASK project	-	77,175	77,175
MCH - project zero to three	102,675	-	102,675
Fund raising and development	27,072	-	27,072
Training of trainers	-	2,368	2,368
Total functional expenses	632,300	234,958	867,258
Supporting Services:			
Management and general expenditures	372,729	2,199	374,928
Total expenditures	1,005,029	237,157	1,242,186
Expenditures in excess of revenue	$ (62,788)	$ -	$ (62,788)

See Notes to Financial Statements

STATEMENT OF CHANGES IN FUND BALANCE
Year Ended December 31, 1989

Fund balance, beginning of year	$384,452
Expenditures in excess of revenue	(62,788)
Fund balance, end of year	$321,664

See Notes to Financial Statements

NOTES TO FINANCIAL STATEMENTS

1. **Nature of activities and significant accounting policies:**

Nature of activities:

The National Center for Clinical Infant Programs (Center) serves as a non-profit, tax exempt scientific and charitable organization. The Center was created by outstanding representatives from the fields of mental health, pediatrics, child development and related fields, as well as community leaders. The Center's goal is to improve and support preventive clinical approaches in the earliest years of life which will facilitate optimal health, mental health, and development of infants, toddlers, and their families. The Center carries out a variety of activities:

- Provides forums for the exchange of information
- Stimulates and coordinates research
- Encourages training of personnel
- Fosters the development of information and public policy in the field of clinical infant programs

A summary of the Center's significant accounting policies follows:

Basis of accounting:

The financial statements are prepared on the accrual basis of accounting, whereby income is recognized when earned and expenses are recognized when incurred.

All grants and contributions are considered to be available for unrestricted use unless specifically restricted by the grantor. A current restricted fund has been established to account for those resources currently available for use, but expendable only for operating purposes specified by the grantors.

Property, equipment and depreciation:

Property and equipment are carried at their original cost or fair market value, if donated, less accumulated depreciation which is computed by the straight-line method over assets' estimated useful lives. Amortization expense of assets acquired under capital lease is included in depreciation and amortization expense.

Income taxes:

The Center has been determined to be a publicly supported organization described in Section 509(a) of the Internal Revenue Code and is exempt from federal income tax under Section 501(c)(3) of the Code. Accordingly, no provision for income taxes has been accrued.

Revenue recognition:

Revenue is received under a cost reimbursement grant from the Department of Health and Human Services as well as from private contracts and grants, contributions, subscription sales, training institute registration fees, and other sources. Grant revenue is recognized as costs, qualified under the grants, are incurred. Grant and contract funds received in excess of costs incurred are recorded as deferred revenue until earned.

The Center offers several subscription plans for its "zero to three" newsletter. Subscribers are given a discounted subscription price when they purchase a two or three year subscription. Revenue for multiple year subscriptions extending beyond the current fiscal year is recorded as deferred revenue until earned.

2. **Obligation under capital lease:**

The Center is the lessee of a mailing machine under a leasing arrangement expiring in 1992 which is accounted for as a capital lease. The asset is being depreciated over its estimated productive life. Depreciation of this asset is included in depreciation expense. Future minimum lease payments under this capital lease as of December 31, 1989, are as follows:

Year Ending December 31,	
1990	$2,136
1991	2,136
1992	178
Net minimum lease payments	4,450
Less amount of interest included	959
Present value of net minimum lease payments	$3,491
Current portion	$1,499
Long-term portion	1,992
Total	$3,491

Interest expense related to the capital lease has been charged to operations in the amount of $937 for fiscal year 1989.

3. **MCH Grant:**

The Center has a cost reimbursable type grant with the federal government. They are reimbursed based upon their direct expenses attributable to the grant plus overhead based upon a provisional rate. Accordingly, if the actual rates (as determined by the Department of Health and Human Services Division of Cost Allocation) are below the provisional rates, a refund for the difference would be due to the federal government. However, based upon computation of the current year's rates, it was determined that the calculated overhead rate was higher than the provisional rate used in requesting the overhead funds. Accordingly, management anticipates that no refund will be due to the federal government.

4. **Major revenue sources:**

Approximately 22% of the Center's revenue for the year ended December 31, 1989 was derived from a federal grant from the Division of Maternal and Child Health, Public Health Service, U.S. Department of Health and Human Services. Accounts Receivable due under this grant totals $78,513 at December 31, 1989.

5. **Grant revenue:**

Included in government grant revenue of $267,135 are funds transferred from various federal agencies to the Center's Maternal and Child Health grant to support the Center's 1989 training institute. The agencies supporting the institute and amount of support are as follows:

National Institute on Disability and Rehabilitation Research - Department of Education	$ 10,000
National Institute of Mental Health	10,000
National Institute of Child Health and Human Development	12,000
Office of Disease Prevention and Health Promotion	5,000
	$ 37,000

Included in grants - foundation revenue of $216,907 is grant revenue from the following foundations:

Smith Richardson Foundation	$ 96,435
Ford Foundation	31,805
Commonwealth Foundation	8,333
Spunk Fund	5,440
Foundation for Child Development	10,417
Metropolitan Life	976
Pitney Corporation	7,681
Van Ameringen	50,000
New Land Foundation	5,000
Oregon Board of Education	900
	$216,907

6. **Subsequent event:**

The Center signed an agreement in February 1990 to lease office space in Arlington, Virginia. The term begins April 1990 and expires April 1998. The lease is classified and accounted for as an operating lease.

Following is a schedule by years of future minimum rental payments required under this lease as of December 31, 1989:

Year Ending December 31,	
1990	$ 70,057
1991	95,457
1992	98,189
1993	101,001
1994	103,879
1995	106,812
1996	26,887
	$602,282

Rent expense charged to operations was $61,698 for the year ended December 31, 1989.

7. **Governmental audit findings:**

The department of Health and Human Services Division of Cost Allocation performs an annual desk audit of the organization's indirect cost rate but has not to date performed a formal audit of the organization as a whole or its specific government grants. As a result of the last audit of the organization's indirect rate for fiscal year 1988, it was noted by the division of cost allocation that the organization was treating as direct costs under some of its private grants costs that were normally treated as indirect costs resulting in inconsistent accounting treatment of similar costs. It was recommended that the organization be consistent in its treatment of similar costs. The organization has complied with this request for fiscal year 1989.

Copies of our complete 1989 audited financial statements are available from NCCIP on request.

1989 CONTRIBUTIONS

Many individuals and institutions contribute a variety of precious expertise to the work of the National Center. Those who contribute funds as well enable us to respond quickly and flexibly to the needs we perceive as we seek to improve the lives of infants, toddlers and their families.

We are deeply indebted to all who have given generously to sustain the work of NCCIP in 1989.

In addition to the donors listed below, NCCIP also received support in 1989 through the Combined Federal Campaign. While we cannot list here the names of the Federal employees who generously contributed support to the National Center, we wish to express our sincere thanks to these donors as well.

Restricted 1989 Revenue

Federal Grant and Contract Support:

Bureau of Maternal and Child Health and Resource Development, U.S. Department of Health and Human Services: Support for Project Zero to Three (Grant #113271); Support for Promoting Success in Zero to Three Services (Grant #115041-02)

Office of Special Education Programs, U.S. Department of Education: Support for NCCIP participation in the National Early Childhood Technical Assistance System (NEC•TAS) (Contract #300-87-0163)

National Institute on Disability and Rehabilitation Research, U.S. Department of Education: Support of National Training Institute

National Institute of Mental Health: Support of National Training Institute

National Institute of Child Health and Human Development: Support of National Training Institute

Office of Disease Prevention and Health Promotion: Support of National Training Institute

Foundation, Corporate and Individual Grants:

Saul Z. and Amy Scheuer Cohen Family Foundation, Inc.: Support of National Training Institute Scholarships

The Commonwealth Fund, Inc.: Support of *Zero to Three*

The Ford Foundation: Support of Better Care for the Babies Project

Johnson & Johnson Baby Products Company: Support of *Zero to Three*

A.L. Mailman Family Foundation, Inc.: Support of National Training Institute Scholarships

Metropolitan Life Foundation: Support of publication on the emotional foundations of early learning.

Pittway Corporation Charitable Foundation: Support of Better Care for the Babies Project

Rebecca Shahmoon Shanok: Support of National Training Institute Scholarships

Smith Richardson Foundation, Inc.: Support of TASK Project

Spunk Fund, Inc.: Support of Fellowship Program evaluation

The Philip and Lynn Straus Foundation, Inc.: Support of National Training Institute Scholarships

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Unrestricted 1989 Revenue

Nurturers ($10,000 or more):

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Publications

of the National Center for Clinical Infant Programs

The National Center for Clinical Infant Programs (NCCIP) produces a variety of written materials for practitioners, policymakers and parents concerned about the development of children and families in the first three years of life. Because publications are distributed through several sources, please follow ordering instructions carefully.

National Center for Clinical Infant Programs

The following publications are available from the

National Center for Clinical Infant Programs
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Zero to Three

5 issues/year	1 year	$18.00
	2 years	$35.00
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Written for professionals working with infants, toddlers and their families, **Zero to Three** includes reports on research in progress, profiles of clinical programs, discussion of current issues in the field, and news of government and private activities, conferences, and publications. Each issue averages 30 pages. Back issues (from Sept. 1980) and Index $4.00/copy.

Policy-relevant research and analysis

Infants Can't Wait, 1986 $6.50/set.

Reviews the developmental tasks and needs of infants and toddlers, describes support available in this country for their healthy development, and documents needs which are not being met. Proposes two major initiatives to ensure basic and specialized services for young children and their families, as well as strategies for implementation at the federal, state and local levels.

Infants Can't Wait: The Numbers, 1986

Companion volume to **Infants Can't Wait.** Documents statistically the birth of infants, the circumstances of their families, risks to their health and lives in the first years of life, their family and community environments, and the sources of their health care.

Maternal Health and Infant Survival: *An analysis of Medical and Social Services to Pregnant Women, Newborns and Their Families in Ten European Countries, with implications for Policy and Practice in the United States,* C. Arden Miller, M.D., 1987 $6.00/copy. Bulk rate available.

Analyzes health care and social supports for pregnant women and their families in ten western European countries with infant mortality rates lower than those in the United States. Analysis, which has major implications for U.S. health policy, reveals a set of strategies which, if implemented, could lead to reduced rates of infant mortality and low birth weight in the United States, and would ultimately reduce public health care expenditures.

Screening and Assessment: Guidelines for Young Disabled and Developmentally Vulnerable Children and Their Families, Samuel J. Meisels and Sally Provence with the Task Force on Screening and Assessment of the National Early Childhood Technical Assistance System (NEC*TAS), 1989 $8.00/copy, $6.00 each for orders of 10 or more.

Presents guidelines for the identification and assessment of children who should participate in programs related to the infant-toddler (Part H) and the preschool (Section 619) components of P.L. 99-547. Focuses on the rationale, core components, and guidelines for establishing a system of screening and assessing disabled and developmentally vulnerable children, birth through age five, and their families.

Shipping and handling charges: $3.20 for orders of 1-2 copies; $4.10 for orders of 3-6; 10% of total purchase for orders of 7 or more.

Child care issues

Finding the Best Care for Your Infant or Toddler, Laura L. Dittmann, 1985. No charge for single copies.

Provides parents with information on elements of good care for infants and toddlers, and answers common questions about choosing care. A brochure published jointly by the National Center for Clinical Infant Programs and the National Association for the Education of Young Children.

Infants, Families and Child Care: Toward a Research Agenda, 1988 $1.50/copy.

Assists the general reader in understanding the vocabulary, assumptions and outstanding research questions involved in infant day care research. Describes areas of consensus reached by 17 leading child care researchers brought together by NCCIP at a "summit meeting" in October, 1987.

Who Will Mind the Babies? Second Edition, 1989 $2.00/copy.

Provides a framework for thinking about the policy issues involved in assuring adequate child care opportunities for infants and toddlers. Topics include: The special needs of infants and toddlers; public policies that support parents who remain at home as well as employed parents; professional recognition and training for caregivers; financing issues; and policy-relevant research.

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Make check payable and mail to

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Zero to Three ☐ 1 year ($18) ☐ 2 years ($35) ☐ 3 years ($45)

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Program evaluation

Charting Change in Infants, Families and Services: *A Guide to Program Evaluation for Administrators and Practitioners,* 1987 $4.00/copy. Bulk rate available.

Suggests that all programs serving young children and families can and should engage in evaluation. Discusses steps that service providers can take to devise evaluation strategies which reflect actual program work and which will provide information needed for program improvement.

Evaluating Service Programs for Infants, Toddlers and Their Families: *A Guide for Policy Makers and Funders,* 1987 $1.50/copy. Bulk rate available.

Reviews and illustrates the kinds of evaluation efforts funders and policy makers may expect from service providers. Suggests steps that funders and policy makers take to encourage mean-ingful evaluation initiatives and to foster the use of findings to enhance the physical and emotional health of young children and their families.

Training

Preparing Practitioners to Work with Infants, Toddlers and Their Families: *Issues and Recommendations,* Emily Fenichel and Linda Eggbeer in collaboration with the TASK Advisory Board, 1990. $5.00/copy. $2.50/copy for orders of 10 or more. Additional price reductions for orders of 50 or more.

Four distinct but related documents have been produced by NCCIP's TASK (Training Approaches for Skills and Knowledge) Project under the general title *Preparing Practitioners to Work with Infants, Toddlers and Their Families.* The four documents are subtitled:

A. *Issues and recommendations for the professions*
B. *Issues and recommendations for policymakers*
C. *Issues and recommendations for educators and trainers*
D. *Issues and recommendations for parents.*

Each document identifies four key elements of training for infant/family practitioners, describes promising approaches, and suggests an agenda for action. Each document also includes material specifically tailored to training issues of concern to its intended audience. Be sure to specify by letter or title the specific document(s) desired.

Shipping and handling charges: $2.25 for orders of 1 or 2 copies; $3.50 for orders of 3-6 copies; 10% of total purchase for orders of 7 or more.

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The following volumes of Clinical Infant Reports are available from **International Universities Press, Inc.,** 59 Boston Post Road, P.O. Box 1524, Madison, CT 06443-1524, tel: (203) 245-4000.

Clinical Infant Reports is a series of book length publications of the National Center for Clinial Infant Programs designed for practitioners in the multidisciplinary field of infant health, mental health and development. Each volume presents detailed case studies illustrating diagnostic and therapeutic issues and methods, as well as conceptual and research material.

Psychopathology and Adaptation in Infancy and Early Childhood: *Principles of Diagnosis and Preventive Intervention,* Report No. 1—Stanley I. Greenspan, M.D., 1981. $32.50.

Presents and illustrates Greenspan's developmental structuralist approach to the classification of adaptive and pathological personality organizations and behaviors in infancy and early childhood, and discusses the implications of such an approach.

Infants and Parents: *Clinical Case Reports,* Report No. 2—Sally Provence, M.D., ed., 1983. $35.00

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The following publications, developed under the project, are available free of charge from the **National Maternal and Child Health Clearinghouse,** 38th and R Streets, N.W., Washington, D.C. 20057, tel: (202) 625-8410.

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Parents who have been associated with Project Zero to Three offer suggestions to practitioners and policymakers about improving the support offered to special needs infants, toddlers and their families at: 1) birth or diagnosis of special need; 2) discharge from the hospital after diagnosis; 3) entry into early intervention; and 4) transition.

Keeping Track: *Tracking Systems for High-Risk Infants and Young Children,* Second Edition, 1989

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Linkages: *Continuity of Care for At-Risk Infants—Opportunities for Maternal and Child Health Programs and Programs for Children with Special Health Needs,* 1988

Reports discussion and recommendations of an 18-member work group convened by the Office of Maternal and Child Health in February, 1988 to examine the need and opportunities for a continuum of care approach for pregnant women and infants.

Serving Culturally Diverse Families of Infants and Toddlers with Disabilities, Penny P. Anderson and Emily Schrag Fenichel, 1989

Provides an overview of the concept of culture in the context of human services delivery; discusses specific cultural issues relating to health, illness and disability; and suggests strategies for enhancing cultural sensitivity in service to young children with disabilities and their families.

The Open Door: *Parent Participation in State Policymaking about Children with Special Health Care Needs,* 1988

Offers recommendations to state policymakers that represent the consensus of many parents of children with special health needs who have been associated with Project Zero to Three.

Warning Signals: *Basic Criteria for Tracking At-Risk Infants and Toddlers,* James Blackman, M.D., 1986

Outlines a basic set of criteria useful in selecting infants and toddlers for inclusion in tracking systems designed to follow children at risk for impaired development.

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as reality (or begin to struggle with the violation of their expectations). Adoption agencies attempt to present as much information as possible to adoptive parents to promote this integration. Open communication between birth and adoptive parents also fosters clarity regarding the baby, bringing fantasy and reality into balance. Given the facts, adoptive parents may be less likely to see the infant as a "blank slate" and more likely to appreciate the specifics of the baby's genetic inheritance.

Grieving for the loss of the fantasied child also helps birthparents to integrate their expectations. When a birthmother expressed her fears about releasing a daughter for adoption, she was helped to see how difficult saying good-bye to her baby would be. She had a chance not only to fantasize about her "daughter" but also to explore her expectations of what her feelings would be at the time of the birth. When this mother gave birth to a son, she may have felt relief that she did not have to face the issues that would have made giving up a daughter so difficult. Her ability to face reality, as she held her son, told him about his life ahead, and gave her reasons for not being able to keep him, was evidence that she had integrated her expectations.

Another kind of "integration of expectations" occurs in adoption. Adoptive parents frequently hear comments that their child "looks just like you" or "has your eyes." It is not surprising that these comments would be made by people who are not aware of the adoption, but it is also common for family and friends who know about the adoption to make such comments. It may be that these people are integrating their own expectations about the biological child the couple might have had with their perceptions of the real child. Their comments may also be a way of expressing their acceptance of the adopted child into the family and community.

The ways in which individuals integrate their expectations about the child who is coming to live with them will teach the counselor how to be helpful in this stage of their psychological development. Acknowledging and supporting the parents' coping mechanisms will assist them through this stage. Attentiveness and listening (Carl Rogers' "unconditional positive regard") may be enough to elicit expression of feelings, and for some adults may represent a "contradiction" of their earlier experiences.

Counselors may also need to assist parents to describe, and then to say good-bye to, their fantasy child. Although expectant parents invariably create a fantasy child, the baby who actually arrives rarely fulfills the fantasy. Although this discrepancy does not usually create a problem, it is helpful to listen to parental feelings about the differences. Because the parents may not expect to have the opportunity to explore their feelings about the differences between their expectations and reality, a contradictory situation is created. Giving them the fullest opportunity to "say hello" to the child of their dreams will help parents express their emotions as they need to before they can welcome their real child. This complete attention to the integration of expectations will lead parents into the final stage of the psychological work of pregnancy, that of bonding.

Bonding

The process of bonding leads us to ask, "How do we fall in love?" The history of trustworthy and safe relationships in an individual's life—of how a person learned to trust and to fall in love—may be revealed in the story of a parent's own infancy. Feelings associated with these early experiences may arise as parents develop a bond with their new baby.

Bonding is a different process for each parent, with each child. If parents have been able to understand and experience the psychological stages of pregnancy and the feelings accompanying them, they are freed to accept the baby as a unique individual, whom they can love without being burdened by unresolved feelings from the past.

Through the creation of their adoption plans, birthparents and adoptive parents are creating a bonding plan. They discuss the birth and early postpartum period, and how and when the baby will be given to the adoptive parents.

An adoption plan that has allowed birth and adoptive parents to create a trusting relationship is one way to begin the bonding process. The birthparents can allow a bond to develop between the child and his adoptive parents because they already know the security of the bond between themselves and these people. The adoptive parents can allow themselves to accept this child fully as theirs because they trust and love the people who have given of themselves.

Through the creation of their adoption plans, these parents are creating a bonding plan. They discuss their plans for the birth and for the early postpartum period as well as plans for how and when the baby will be given to the adoptive parents. They clarify how much contact the birthparents would like to have with the child. They think together about how they will tell the child about the adoption and the reasons for the birthparents' decision to give the child to his adoptive parents. The mutual support these parents give each other supports the bond that will develop between the adoptive parent and the child.

Trust and support between birth and adoptive parents help to prevent interruptions in the bond between the adoptive parent and child. The finalization of the adoption may take months to occur, a time when the birthparents can change their mind. Fearing the loss of the child, adoptive parents may not bond fully with the child until the adoption is legal. Adoptive parents have spoken of feeling that they are being "held ransom" and have expressed their wishes to do anything to accomplish finalization quickly. Work toward finalization that can be done before the birth—even if adoptive

and birthparents are not in direct communication—will help allay adoptive parents' fears and promote their bond with the child. The birthmother's ability to tell her newborn about the adoption and to give the adoptive parents pictures and letters describing the reasons behind the adoption plan will open the doors to a trusting relationship between the child and the adoptive parents. This process also helps the birthparents to say good bye to their child and begin looking to their future.

Not infrequently, adoptive parents receive their child and settle legal aspects of the adoption away from home. Although attending to the needs of a newborn in unfamiliar surroundings may be difficult, this process may allow adoptive parents to focus entirely on the infant and their developing bond without the distractions of home. Attention to legal issues may feel to these parents like their "labor and delivery." They will feel the intensity of their work because of sleep deprivation and dealing with the unknown. The support and caring of lawyers, hospital nurses and doctors, as well as friends and family calling to keep in touch, will give them energy so that the bonding process can unfold.

Adoptive parents may have preconceived ideas about bonding that warrant exploration. One adoptive mother spoke of her confusion about "this bonding." She expected some magical connection, perhaps an outpouring of breast milk or the powerful internal feeling that she had heard a mother describe in connection with her biological child. She had heard her sister-in-law say that her ten-day-old baby would turn to her voice and even move his body in her direction when she spoke, but she could also observe that her own baby could be held by anyone and not complain. That it is developmentally normal for a newborn to be content when held in loving arms was not considered by this adoptive mother. Her concerns about differences between adoptive and biological bonding kept her from appreciating the naturally developing attachment between herself and her child.

The quality of the support available to new parents, whether adoptive or biological, affects the development of the bond with their baby. Acceptance of the child by family and community nurtures the bond with the child. For adoptive parents, contact with other adoptive families, continued contact with a caseworker, and reading about adoption issues can provide needed support.

Counselors need to listen for specific signs of distress. If family members are suffering from lack of sleep, they need to arrange for nap times. Assistance with prioritizing household needs and organizing necessary tasks can relieve some tensions. Asking parents where they learned about babies may lead them to teach the counselor about their own childhood, and how they learned about trust and falling in love. An effective counseling exercise for adoptive parents is saying, "This is *our* baby!" If this statement contradicts their unspoken feelings of doubt about their bond, their feelings will be expressed behaviorally and can be explored. Listening and observing will convey a sense of caring. Giving adoptive parents feedback about their successful interactions with their baby also helps promote the development of their bond.

Conclusion

The process of adopting a child requires many real adjustments in parents' lives. It also elicits a variety of different, and often difficult, feelings. Using the framework of the "psychological work of pregnancy" as a model for examining the adoption process helps to normalize the feelings that adoptive parents are likely to experience. Counselors who understand the theory and integrate it into their clinical practice may be better able to promote the healthy psychological development of parents and children during this time of change, whether the adoption involves open communication between birth and adoptive parents or an agency providing information to the parents. Of prime importance is for all involved to understand the "psychological work of adoption" as normal and, indeed, necessary. Adoptive parents need opportunities and encouragement to acknowledge and express their feelings as they arise so that their attention will later be freed to focus on the needs of the child. And it is this ability of parents to focus on the baby's needs, free of past distress, that may be the surest safeguard of the infant's mental health.

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Correction:

The February, 1990 issue of *Zero to Three* failed to mention all the organizations that collaborated to establish the Infant Advocacy Council and the T. Berry Brazelton Infant Mental Health Advocacy Award in Texas. These organizations are:

Association for the Care of Children's Health: NTX Affiliates, Dallas Psychoanalytic Society, Early Childhood Interagency Council of Metropolitan Dallas, Mental Health Association of Dallas, Mental Health Association of Texas, North Texas Behavioral Science Foundation, Texas Association for the Education of Young Children, Texas Association for Infant Mental Health.

Preventive-Intervention Groups with Adoptive Parents and Their Babies: Minimizing the Risks to Emotional Development in the First Three Years

by

Elaine Frank, M.S.W. and Denise Rowe, B.A.
AFTER ADOPTION, Philadelphia, Pennsylvania and Infant Psychiatry Program, The Medical College of Pennsylvania

Scott is an energetic three-year-old who is playing with some children when suddenly, for no apparent reason, he bites his playmate. His mother sees it happen from across the room. She is enraged and goes to him, saying he should not hurt the other kids. As Mrs. D. tries to discipline Scott, she becomes paralyzed by her fear that her anger will cause Scott not to love her. Suddenly she holds him, caressing him and saying, "I love you." At first he is ambivalent and pushes away. Then he succumbs.

Patty, three months old, is screaming in her mother's arms. Mrs. G. is walking down a crowded urban street, pushing the baby carriage. She is enraged at her infant, momentarily hating her. As she later describes the scene, her eyes well with tears; Mrs. G. is once again overwhelmed by her ambivalent feelings about motherhood. "How could I have wanted a baby so much, waited so long, and had to go through so much to get her, and then get so angry at her?"

If a rose is a rose, and parenting is parenting, what makes adoption different? Although Scott and Patty present parenting dilemmas that could occur in any family situation, in the adoptive family these dilemmas can be influenced by unresolved infertility issues and background ghosts in the family. While adoption itself may not impose problems on the parent-child relationship, there are risk factors that can influence the parent's ability to parent effectively, thus increasing the potential for disturbances in adoptive children and their families.

In our previous work with parent-infant groups (Frank, Rowe, 1981, 1986), we have seen that parenting in general can be enhanced through education. Parents who are able to learn about, understand, and accept early emotional development are more empathic and do a better job of parenting. When adoptive parents can discuss and deal with emotional development and adoption issues at the same time, they are likely to have an easier time bonding and forming a close parent-child relationship.

We began Adoptive Parents Groups when we became aware that an adoptive parent in a biological parent group was often at a disadvantage. Some adoptive mothers did not want to listen to other mothers discuss the birth and delivery of their child. Others did not want to discuss adoption with mothers they thought would "not understand." In the adoptive parents' group the mothers feel more at ease with each other and seem to form a special camaraderie.

Both Scott and Patty are adopted children. One family attended our parents' group before adoptive groups were available. The other family has been a member of the first adoptive parents' group for four years. Our work with each family will be described in some detail later in this article.

In trying to understand what makes the adoptive family different, one must consider the following questions. Is it possible to separate the child's development from his or her adoptive situation? Are infertile couples different in their parenting behavior from biological parents in discernible ways? Are adopted children more prone to suffer from childhood emotional disorders, behavior problems, adolescent identity problems and, eventually, adult psychiatric disorders? If so, are the problems caused by parents, genes, environment? Can adoptive families be helped so as to prevent or deal with such problems early in the child's life?

While searching for answers to these questions, we became convinced that the risks to healthy early emotional development, if not recognized and dealt with to some extent, can present themselves as "ghosts" in the adopted child's "nursery" (Fraiberg, 1975).

Risk factors inherent in the adoption situation

Parents' reactions to infertility

Couples who do not have the opportunity to deal with their feelings about their infertility may have difficulty in the adoption situation. Participants in private adoptions in the United States often have no services available for such exploration of feelings, unless the prospective parents seek out organizations like RESOLVE or mental health professionals involved in infertility and adoption.

Some adoption agencies now provide services, which may range from a few brief encounters to post-adoption groups. Often, one or both spouses have not explored their feelings about infertility before beginning, or even completing, the adoption process. If parents do not resolve significantly their feelings about being unable to conceive, they may not have sufficient emotional energy to relate positively to the adopted child. Sometimes adoption is chosen with the idea that the woman will conceive after the adopted baby arrives. This in fact happens in only 8 to 14 percent of cases. Some adoptive parents continue medical treatment for their infertility after they have adopted a child. If parents are then able to conceive a child, they will have to confront conflicting feelings in themselves and their children.

Loss of the hoped-for biological child

Parents typically have fantasies about the baby they will have. Women especially may have fantasized from girlhood about what their baby might look like and what sex the baby might be. The adopted baby may not fit these fantasies. Parents must grieve this loss and come to terms with it, even though they may not fully recover from or resolve the loss. This parental experience will

be important if and when the adopted child grieves for his "lost" biological parents.

Lack of pregnancy as a developmental phase

During pregnancy, future parents have the opportunity to think about, discuss, and possibly come to terms with issues of parenthood. Changes in lifestyle, attitudes about child rearing, and issues of responsibility are some of the things prospective parents try to deal with before the baby arrives.

Couples in the process of adopting often do not want to think about the baby. Some feel that if they count on the adoption being successful, the birth mother will change her mind and keep the baby, leaving them devastated. Since they don't want to think about the baby, they don't think about other issues connected with parenthood either.

When the baby is born and released for adoption, parents may have only a few days to prepare. This adds to the stress of an already anxious situation.

Legal and psychological uncertainties in the adoption process

Some adoptive parents worry that they won't like the baby or be able to relate to him. They ask themselves, "What will the baby look like? How will the baby act? What kind of temperament will he or she have? How will we be able to understand the baby if he does not have our genes?" Often parents stop pondering these questions once they have the baby, but if parents are unable to adjust to the reality of the particular baby they adopt, bonding may be difficult.

Even after the parents receive the baby, they may have difficulty concentrating on parenting. In many states, the legal process of adoption takes up to a year, and in the first several months the birth parents can change their minds. Many adoptive parents say they are anxious every time the phone rings. Sometimes they feel uneasy about getting too attached to the baby.

Unconscious issues about "entitlement"

Some women may feel that because they could not get pregnant or could not carry a pregnancy to term they won't be able too keep the adopted baby. In other cases, parents may think that the adopted child is so "special" that they don't deserve him. Other parents, however, may feel that the adopted child will never be good enough for them.

Parent's and child's reactions to the "telling process"

There has been a range of theories and conflicting opinions about telling the adopted child his story. In years past, many thought the child should never be told of his adoption. Often the child found out anyway and was hurt and angered by the secret. Many adult adoptees have worked to change agency and social policies. Recently, many professionals and adoptees have felt that the story should be told very early and very often. We are concerned that the story be told slowly over the years, as it can be handled emotionally and cognitively by the children.

Sociocultural attitudes toward the members of the "adoption triangle"

As much as we hate to admit it, there are still numerous negative reactions to adoption in our society. Many adoptive families are hurt and dismayed by remarks made to them by family, friends and strangers. Some parents are able to develop responses they are comfortable with as they become more at ease as parents. Others continue to be anxious when offensive remarks are made, and have difficulty dealing with their feelings, especially when their children are present. Their anxiety may in turn impair their ability to be at ease talking about the adoption situation with their children.

These risk factors to healthy emotional development, coupled with everyday parenting issues and child development theory, are discussed in prevention-early intervention parent-child groups in ways that are educational and supportive to adoptive parents. Our goal is to prevent crises through education and to promote parental empathy by developing family relationships based on a strong emotional bond, mutual respect, and understanding of young children's behavior.

History and design of program

The Infant Psychiatry Program at the Medical College of Pennsylvania began offering groups for adoptive families in 1986. They were a variation on the original program, begun in 1975 to teach parents about the emotional development of their children from birth to four years. We believe that encouraging early attachment and a close parent-child relationship promotes healthy emotional development. As parents learn about their child's emotional development, they become more interested and motivated, more flexible and available to their child's needs.

We added a program specifically for adoptive families with the idea that they might be more comfortable in groups where pregnancy, delivery and nursing were not so much a part of group discussions, and where they could describe the circumstances and express their feelings about adoption. Until recently there has been a dearth of post-adoption services. Many families are not comfortable returning to an adoption agency with child development and parenting questions, especially when they still feel worn out from the pre-adoption process.

We knew that despite some preparation for parenting during the adoption process (usually limited to agency adoptions and thus not reaching participants in the growing number of independent adoptions), adoptive couples frequently had little knowledge about parenting or child development. They were often afraid to allow themselves to plan for child rearing, fearful that the adoption effort would be unsuccessful. Post-placement parent education and knowledge about child development seemed critical for these families.

If, in the early years, parents and child can forge a strong relationship and learn to communicate about emotional issues, adopted children are likely to be able

to negotiate successfully the pains of learning about their particular adoption story. Our adoptive parents' groups were designed to give parents opportunities not only to talk about child development but also to discuss adoption issues, including infertility, birth parents, lack of medical information, and "telling," while the children were still small and in the context of the stages of early development. Parents also tend to be interested in discussing how to respond to and educate family, friends and the community about adoption.

Educational content of the groups is based on psychodynamic theories of infant and child development, most specifically Margaret S. Mahler's studies and observations of separation-individuation. We also base our approach on the work of theorists such as Rene Spitz, Eric Erikson, Anna Freud, Selma Fraiberg, Donald Winnicott, and John Bowlby, as well as on the insights of attachment and parenting researchers and teachers such as Mary Ainsworth, T. Berry Brazelton, Stanley Greenspan, and Sally Provence. The method of a "laboratory classroom" including parents, children under four, and the group leaders was created by Dr. Henri Parens.

Adoptive family groups meet weekly during the day for one-and-one-half-hour sessions. Groups are also offered in the evening for parents only. Before joining a group, each family meets individually with the leaders, and individual sessions are scheduled for each family at the end of the year as well. The year is divided into two semesters; parents can attend for up to three years. Fees are on a sliding scale.

In the adoptive family groups, two leaders teach parents to observe their own and the other children. The leaders comment on the children's behavior and its correspondence to developmental stages. Group discussion focuses on behavior, emotional expression, and communication between parents and baby. Parents can follow their child's development through the process of separation-individuation, and learn growth-promoting ways of communicating with their babies and toddlers. They learn what progression of development is normal and what can be expected next. By understanding developmental tasks and timing, they are able "to put themselves in their children's shoes" and to see themselves as facilitators and partners in a lifelong relationship.

By adding discussion about adoption issues to discussion of development, parents are able to explore their feelings and consider solutions to some of the questions about development and family life raised by the adoption situation.

Topics and themes in group discussion

In the first year of life, the attachment process between baby and parent is paramount. We have not seen differences between adoptive and biological pairs in behavior of mother and baby. We do see a self-consciousness in adoptive parents, and a belief in the myth that biological parents would have an easier time. When faced with normal problems like colic, or temperamental discrepancies between mother and baby, the adoptive mother worries that her instincts "aren't working right," or that she would know just what to do if she were the biological mother.

The first questions that adoptive parents typically discuss in the group are, "Will the baby love us?" "Will we love the baby?" and "What if the baby isn't what we imagined?" As they learn more about attachment and their own responses to the baby, they become more comfortable. They grow more interested in their baby's developmental progress and their own parental identity.

Adoption topics in the first six months are telling relatives and friends, and how reticent or forthcoming to be in talking about adoption. Parents' choices range from telling the world to not telling one's own parents about the details. Since becoming an advocate for one's child is a facet of a new parent's role, the issue of whether adoptive parents feel obligated to become educators to their families and the general public produces lively discussions in early group meetings while young babies sleep.

As attachment proceeds and sleep deprivation recedes, parents feel calmer, until the baby, at seven or eight months, begins to creep away from them. The psychological separation process starts. Parents say "No" for the first time. They learn about stranger and separation reactions, individual personality traits and negativity. They realize they must become limit-setters and frustrators as well as stimulators.

If the adoption has been finalized, many parents want to forget it for awhile. Their questions veer in the direction of "just plain parenting." Adoption as a topic fades as the baby learns to walk and parents thrill to the first words.

Babies in what Mahler calls the "practicing" stage (the period, from 10-15 months, in which the baby becomes able to separate from mother by crawling or walking) demonstrate a normal upsurge of aggression, which precipitates concern in most parents. They find themselves getting angry at their baby (a difficult experience for adoptive parents who had to work so hard to get a child). They wonder if they will lose control of their upright, but uncivilized creature, whose favorite word is "No." The little one's repertoire might now also include throwing things, hitting, biting, and pinching, directed mostly at parents but also at peers.

Parents begin to wish for more distance from the baby—perhaps a vacation without the child, business trips, or a return to work. Handling separations is discussed in the group, and parents struggle with how important their children are to them, despite their wishes for separateness.

From the middle of the second year, the child's ambivalent urges toward autonomy, separation anxiety, and faulty control of aggression—all a normal part of the "rapprochement" stage—cause biological parents to worry about their toddler's emotional stability. Adoptive parents wonder if problems from their child's unknown genetic history are surfacing, or whether troublesome behavior is due to some unknown aspect of the adoptive situation.

If the normal anger and aggression of young children take adoptive parents by surprise, parents also begin to wonder what will happen when their children are rebellious teens, or want to search for their birth parents. They often feel guilty when they respond to their child's tantrums with anger of their own. Handling tantrums, setting limits and encouraging expression of feelings are on the group agenda now. As the leaders teach parents about what to expect, parents are asked to express their concerns and to try out in advance ways of handling both their feelings and their children. From our original groups we learned that many biological parents are not prepared for these experiences either, but adoptive parents often wonder more intensely about the "ghosts" of birth parents at this time.

Between two and three, the normal child becomes fearful, especially of being left, lost, or not loved by parents because of bad behavior. These fears often coincide with parents thinking they should be explaining adoption to their child. The child is developing a conscience at this time and consolidating his or her identity as a separate person. Our opinion, based on observation as well as current research on personality development and adoption, is that the child of this age is really unable to entertain the idea of two sets of parents. Also, being "given away," no matter what explanation is offered, is so frightening as to be disorganizing to the young ego. Although the content of these fears may change in the early years, underlying themes of separation and abandonment remain constant. Parents learn about these fears, and air their worries about birth parents, beginning to think about how they will eventually explain the birth parents to their child (See sidebar on "telling").

Through all of the discussions, the leaders stress the importance of communication with one's child from an early age, especially about feelings and relationships. The strength and quality of the parent-child relationship is the most important factor in building self-esteem and contributing to a comfortable acceptance of adoption. Acceptance by the parents of who their child is and how he or she became theirs has been correlated with a high level of self-confidence in adopted children (Hoopes and Stein, 1985 and DiGiulo, 1988). As the child nears three, verbal communication becomes much more a two-way street. Child and parents are more likely to have forged a sturdy partnership that will allow them to face the challenges of integrating and making sense of each child's specific adoption story.

Case examples

Scott and his mother

Scott is a two-and-three-quarters-year-old boy who has been attending group with his mother since he was 17 months old. He is a high-energy, exuberant boy who only recently learned to talk. He has always been aggressive to his mother, and since about 19 months he has also bitten and pushed his peers. His mother is unhappy about his aggression. Although Mrs. D. is slow-moving, she tries to intervene when he attacks another child. Nevertheless, Scott manages to push or hit several times during each group session.

When frustrated in his aggression by his mother, he usually hits or bites her. She tries to prevent this, tells him "no", holds his hands, and when he starts to cry, cuddles and strokes him while saying, "Don't hurt Mommy."

The group leaders talk about aggression at this age, relating it to the child's attempts to separate from mother and gain control of body functions, which include elimination and actions capable of hurting other children. We tell parents that clear and specific limits help the child get control of himself or herself, and that parents should prevent the child's striking out when they can, and tell the child that hitting hurts. We also discuss how hard it is for parents to face their child's anger at them, but the child needs to know that Mommy won't be destroyed by anger and can stand firm with limit setting.

This is where Scott's mother turned into mush. She could not bear Scott's fury at her, felt guilty, and cuddled and kissed him each time he attacked her. This was confusing to Scott and to his budding efforts to control himself. Scott did discover a way to help himself. He held mother's hand when he crossed the room to get a toy, so that she was between him and his usual victims.

We explained to mother that Scott needed her help to keep his hands to himself. Holding her hand prevented him from hurting his peers. However, when he was angry at his mother, he was helpless, because she would hold and hug him so soon after she reprimanded him that he had no opportunity to stop hitting her by himself. He seemed stuck and unable to progress, as most children do, to a measure of self-control and, eventually, an ability to use a verbal reminder from mother, rather than her physical presence, to stop his aggression.

Although we tried in a general way in the group to address parents' guilt about limiting their children's aggression, Scott's mother was unable to modify her ambivalent behavior.

Discussion

Since Scott was not in an adoption parent-child group, there had been no discussion about adoption issues, although we did know that Scott was adopted. In an adoption group, we would have discussed the concerns of parents about discipline, limit setting, and the normal outbreak of aggression during the second year. We would also have talked about how common to the adoption situation is the kind of guilt Scott's mother showed in her mixing of reprimand and affection. There would have been encouragement of mother's expression of her concerns that Scott would cease to love her if she showed anger toward him or set firm limits on his aggression.

Scott's parents had experienced several "false alarms" in their attempts to adopt, including a placement that fell through after three days. Mother was overwhelmed

The "Telling" Process

"Ma, did I grow in your tummy?" is a question from one's three-and-a-half year old that is often greeted with apprehension and anxiety by a parent who has to decide quickly if he or she is ready and able to begin explaining the mysteries of pregnancy and birth to the child. This question brings special concern to adoptive parents. Is this the time to tell about the birth family? What effects might such information have on the child's self-esteem, on the parent-child relationship?

A child's understanding of adoption grows and changes slowly over years. What does it mean to know about one's adoption at age 3, 6, 10, or 15? How are the adult's and child's needs to explain and to hear different from one another? When, how what and how much to tell? Are there particular times when this information is *not* welcomed?

We think the initial tellings are easier on the child than the parents; and the more the parent has had experience thinking and talking out reactions and feelings, the more tolerable and meaningful will be the conversation.

Telling about adoption is more important to the parent than to the young child. It is not the child's urgent interest. The child has other more immediate questions on her mind; like life and death, and sex, and where jelly beans come from, and where she left her blanket before bed. To the child under seven these questions are more compelling than "Where did I come from?" and "How did I get here?", which are usually of more interest to older children or young adults.

In order to understand the concept of adoption the child has first to reach some psychological separation from parents as well as a cognitive understanding of conception and birth. Only then can he or she hope to make sense of a particular story and digest the emotions that arise from that understanding.

We do disagree with the idea of "early and frequent" telling, especially about the birth parents and the circumstances of relinquishment. Detailed information about "another mother and father" can be confusing and harmful to the parent-child bond before the years of middle childhood (age 7 or 8). We are not talking about children who were placed after infancy or who have had several placements, multiple experiences, and memories which they need to be helped to process and understand.

In groups for adoptive parents and children we compare discussing adoption to discussing sex with children. You need to explain a little bit and answer questions, then wait for a response. This doesn't mean you don't mention the word adoption earlier, or talk about it in the child's presence. We do—after all this is a group for adoptive families!

Michael's mother reminds him that he's adopted every so often—he's two-and-a-half—but she admits it's more for her sake than his, that she is practicing for the future.

The more parents can understand the normal stages of psychological and cognitive growth, the better able they will be to introduce the adoption story and maintain an ongoing dialogue. We hope the conversation will grow with the child's capacity to understand and will help to cement family ties.

and depressed the first few weeks with her son, hadn't thought parenthood would be so difficult, yet was overjoyed to be a mother. In an adoption group that particular mix of feelings would have been expressed often by others, accompanied by discussions about how people came to terms with their infertility, and speculation about the effects these experiences would have on their child rearing.

A toddler's normal aggression can cause parents to fear they will lose control of their child, that he or she will never become a civilized adult. Parents' angry responses to being hit by their child can be frightening to them, especially if they find themselves beginning to use physical punishment. Adoptive parents may worry about their own propensity for aggression, as well as whether their child will reject them if they scold or punish. They may also become preoccupied with fears that their discipline now will cause their child to "search" for biological parents in the future. Sometimes they wonder about their child's genetic history, fearing that the child's behavior is a precursor of psychiatric illness or delinquency.

All of these thoughts were entertained by Scott's mother, as we learned later (Mrs. D. was referred for individual psychotherapy), but they did not emerge in group. Since our original parent groups were educational, rather than therapy groups, we did not delve into these topics specifically. In the adoption groups, however, these subjects were brought into focus from the start as legitimate work for the group. Had we known and been able to concentrate on some of these adoption themes, Mrs. D.'s understanding of both her child's development and her own identity as an adoptive parent would probably have been deepened. She could have been more supportive to Scott during a difficult, intense period for him, and at the same time strengthened her own confidence as an effective parent.

Patty and her mother

Patty and Mrs. G. began attending the Adoptive Parents Group when Patty was two months old. Patty's parents had been married for several years before they received Patty through a private adoption, a few days after her birth.

Patty is a sensitive child. Even as an infant she reacted excessively to situations she did not like. From a very early age she wanted to be upright and would cry (at times in a rage) until she was picked up. When bedtime and sleeping in her own crib became issues at about 10 months, she would stand and cry, sometimes until she vomited, if her parents would not respond to her.

In toddlerhood, Patty at first was passive and somewhat shy. Later she became aggressive and showed behaviors such as hoarding and bossiness. She would bite her mother when angry at her.

For all her negative behaviors, Patty was and still is an alert, intelligent and delightful child. She is curious and inquisitive and can discuss her feelings and reasons for her behavior in ways that seem well beyond her years.

Mrs. G., on the other hand, was limited from the first in her ability to meet the challenges presented by Patty. When responding to Patty's undesirable behavior, Mrs. G. had difficulty setting firm limits and discussing the reasons Patty was angry or misbehaving. Even in response to Patty's questions and comments, Mrs. G. was unable to be candid if she felt Patty would be distressed by an honest answer. She would substitute an evasive but more "pleasant" reply for the truth, or would simply change the subject. (Our sense was that Mrs. G.'s concerns tended to reflect her own anxieties rather than Patty's immediate worries).

Because mother and daughter attended the adoptive family group from early in their relationship, we were able to discuss these and other issues as they evolved. This process enables a parent to assimilate parenting and developmental information as he or she experiences the situation, rather than discussing it "after-the-fact." Several issues that were troublesome for this mother-child pair emerged in the group. Mrs. G. needed to understand her angry feelings toward her daughter when Patty was aggressive or bossy. Patty needed help in learning how to express herself acceptably when she was angry, but she also needed a more intense closeness with her mother than did some of the other children.

Although Mrs. G. was very good at bringing up questions in the group, she seemed more interested in strategies for management of behavior and had more difficulty with identifying and addressing emotional issues. As we observed this pair in the group, it became apparent that these limitations might impair the family's ability to deal with the adoption situation.

Intervention and discussion

Mrs. G. needed supportive encouragement to learn how to accept Patty "as she was" and to begin to set limits in ways that were empathic to Patty's emotional needs. Although at times this was not easy, Mrs. G. was eager to learn and could understand intellectually what was needed.

When Mrs. G. became concerned that Patty would be "too dependent on her," we discussed the separation-individuation process in the first several years of life. Mrs. G. thought originally that her working part-time would give Patty the opportunity to become independent. After learning that children will have to bond and then separate over a period of two to two-and-a-half years whether or not the parent works outside the home, Mrs. G. was able to spend time being really close to Patty and interacting with her appropriately. There were times when Mrs. G. would joke about having to do what Patty wanted even though Mrs. G. would rather be doing something else.

The group helped this mother-child pair deal with two issues that can often be risky for adoptive families: the lack of fit between parents' fantasy child and the real child, and the difficulty of "telling." Whatever her fantasies about "ideal babies" might have been, Mrs. G. appeared to have some difficulty accepting Patty's actual temperament and personality. Mrs. G. has worked hard to understand Patty "as she is" and to help Patty with her sensitivities as well as her aggression. By coming to terms with her own expectations and her sometimes negative reactions, she has been able to encourage Patty's positive behaviors effectively and to set limits on the aggressiveness.

Mrs. G. often had difficulty answering Patty's questions or discussing things with her that Mrs. G. felt would bring "sad" or "bad" news. Not surprisingly, therefore, the idea of discussing adoption upset Mrs. G. On several occasions Patty herself asked questions which were perfect "openers" for such a discussion. When Patty asked her mom if "babies came out of the TV," Mrs. G. simply said "No" and changed the subject. After talking about this exchange in the group, Mrs. G. understood how she could have taken the opportunity offered by Patty's question to explain something about how babies are born, or to ask Patty if she had any ideas about it. After several sessions during which Mr. G. brought up examples of situations that might lead appropriately to a discussion about babies or adoption, Mrs. G. began to be less anxious. She also received support and encouragement from other mothers who had children close to Patty's age, as they went through similar experiences.

We feel that Mrs. G. has done very well in overcoming these parenting dilemmas. Her relationship with Patty has been enhanced by her continued interest in learning about and understanding the particular needs of her daughter.

Benefits of post-adoption groups

Post-adoption services that help families continue to work on the issues of infertility and adoption remain scarce. Services vary depending on the nature of the adoption process—agency, private, foreign, semi-open, or open.

The benefits of a group that combines parent education with explorations of the adoption experience are several. The group provides an environment in which adoptive parents can work on issues in the presence of others who share them in some way, and who have similar motivation to learn about their babies and themselves in their new parental role.

The experience of parenting, for which adoptive parents have waited so long, is exciting and rewarding. However, as with anything hard-won, there can be anxiety in the midst of satisfaction. Adoptive parents have been thrust abruptly into a situation for which they were over-prepared but under-experienced.

In addition to providing a valuable learning experience, the adoptive families group is supportive emotionally. It provides opportunities for friendship with both adults and children in similar circumstances. In the group, adoptive parents can obtain the same information about emotional development that we feel all parents need. Members are supported by others who have shared not only their baby tending dilemmas, but also their infertility experiences and the adoption process.

Like all of the parents with whom we work, adoptive parents gain enormous satisfaction from beginning to understand their own child's development. They feel that parenting not only presents them with their greatest challenge but also results in the most enriching of human bonds—family ties.

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Publications

Adoption Factbook: United States Data, Issues, Regulations and Resources (1989)—National Committee for Adoption, 1930 Seventeenth Street, N.W., Washington, D.C. 20009-6207) $20.80.

Federal data collection on adoption ended in 1975. In 1985, the National Committee for Adoption (NCFA), a private non-profit organization founded in 1980, published its first *Adoption Factbook.* The 1989 edition contains four major types of new and updated information:

- Current adoption regulations—State regulations, including regulations on access to adoption records; Immigration and Naturalization Service regulations for foreign adoptions; legislation on adoption registries; and regulations on surrogate motherhood.
- Adoption statistics—previously unpublished data from NCFA's 1986 national survey on adoption; INS data on foreign adoptions; trend statistics; and NCFA's recommendation for a Federal/State data collection program.
- A discussion of adoption issues—transracial adoption; foreign adoption; pros and cons of public, private, and individual adoption; rights of birthparents and costs of adoption, among others.
- Adoption resources—adoption specialists, support groups, organizations, and programs designed to help lay persons and professionals.

NCFA estimates that in 1986 there were 51,157 unrelated domestic adoptions and 10,019 foreign adoptions in the United States. Infants comprised 48.1 percent (24,589) of all unrelated domestic adoptions in 1986 and 64 percent of foreign adoptions in 1985-87. The 24,589 infant adoptions represented 0.7 percent

of all U.S. live births and 2.8 percent of all U.S. live births to unmarried women in 1986.

Adoption: A Handful of Hope (1990)—Suzanne Arms (Celestial Arts, P.O. Box 7327, Berkeley, CA 94707) $12.95.

This volume is an updated and expanded version of the author's 1983 book on adoption, *To Love and Let Go*, which included a number of true stories "to show the impact closed adoption had on people's lives and then to show what open adoption could offer." The current volume includes the stories from the earlier book, updates on every person, and a number of new stories. The perspectives of birth parents, adoptees, adoptive parents, and an adoption attorney are presented.

The author notes: "Open adoption—adoption where the initial bond is not severed and where the child is not left to feel abandoned by a mother and father he or she does not know, and where the adoptive parents and birth parents create the adoption from a relationship they have created together—is a sane approach to adoption for everyone involved. I believe people need to know the hazards of assuming that they can find their way through the lifelong process of adoption on their own—without maps, skilled guidance, and a community of support."

Saying Goodbye to a Baby: Volume 1, The Birthparent's Guide to Loss and Grief in Adoption; Volume 2, A Counselor's Guide to Birthparent Loss and Grief in Adoption (1989)—Patricia Roles (Child Welfare League of America, Inc. 440 First Street, NW, Suite 310, Washington, DC 20001-2085) Volume 1, #12.95; Volume 2, $10.95.

The author, a birthmother who, at age 18, placed her infant daughter for adoption and subsequently became a social worker, notes that "all three parties in the adoption triangle experience some kind of loss. The adoptive parents have to deal with their infertility, and mourn their inability to have their own biological child. Adopted children go through the separation from their birthparents early in life. As they become adolescents and adults, they have to deal with the gaps in their knowledge of their own roots, and may interpret their relinquishment as rejection ... It is only recently that professionals in the field of adoption have begun to realize and acknowledge that a grief process occurs following reliquinshment of an infant." In *The Birthparent's Guide to Loss and Grief in Adoption*, Roles uses the experience of three birthparents to illustrate discussion of the adoption decision, the pregnancy and birth experience, aspects of normal grief reactions, the birthmother's adjustment after labor and delivery, looking back on the adoption decision, living with one's decision, issues for others in the adoption triangle, reunion, and the need for outside help. In *A Counselor's Guide to Birthparent Loss and Grief in Adoption*, Roles offers a framework for conceptualizing grief in adoption and suggests strategies for adoption reform at the community level as well as issues in preadoption and postadoption counseling.

The National Directory of Children and Youth Services 1990-91: The Professionals' Reference, Sixth Updated Edition (1989)—Marion L. Peterson, Publisher, P.O. Box 1837, 1761 Cove Ct., Longmont, CO 80505-1837) $63.00.

This 715-page directory not only lists the agencies and individuals in states, counties and major cities that provide human/social services, health care and welfare, juvenile justice and special services; it also explains how each state renders its services, so that the reader can judge whether to call a county office, a regional administrator, or a state agency. The second part of the directory, "Who's Who in Federal Children and Youth Programs," includes the names, addresses and telephone numbers of administrators in the major federal agencies; staff of Senate and House committees involved with children and youth; national resource centers and clearinghouses; and private non-profit national organizations, both service and professional.

Reaching Out: A Directory of National Organizations Related to Maternal and Child Health, Third Edition (1989)—National Center for Education in Maternal and Child Health (NCEMCH, 38th and R Streets, N.W., Washington, D.C. 20057) Free of charge.

This 118-page directory, compiled by the National Center for Education in Maternal and Child Health with support from the Office of Maternal and Child Health, Bureau of Maternal and Child Health and Resources Development lists both national organizations and self-help clearinghouses in the United States and Canada. Listings of national organizations include those concerned with pregnancy and childbirth, infant health, child health, adolescent health, school health, women's health, nutrition, genetic services, chronic illness and disability, special health care needs, public health programs and services, and health care providers. The directory also includes a detailed subject index and an alphabetical list of all organizations.

Social Services for Children, Youth and Families in the United States (1989)—Sheila B. Kamerman and Alfred J. Kahn (Annie B. Casey Foundation, 31 Brookside Drive, Greenwich, CT 06830) $20.00.

This report presents findings and recommendations from a two-year study, co-directed by Sheila Kamerman and Alfred Kahn of the Columbia University School of Social Work and funded by the Annie E. Casey Foundation. The authors visited 25 social service systems that provide child welfare and child protection services, adolescent pregnancy and parenting services, parent education and parent aide services, and other services under a variety of arrangements, in order to provide an overview of problems and patterns of coping among social services for children, youth and families nationally.

The authors note that the widespread presence of "targeting," on the premise that public resources are limited, "means a general acceptance of the social service system's inability to undertake much prevention activity or to offer much service to those with chronic problems

which do not explode dramatically—or have not as yet." Some social service systems, however, embrace what Kamerman and Kahn call a "new vision"—i.e., "placing the child and family service response in a community development context, emphasizing community 'ownership' of children's problems, and seeing the social service component only as the direct, formal service element in a network where others should 'prevent', 'case find', and help cope."

The Course of Life, Volume II: Early Childhood (1989)—Stanley I. Greenspan and George H. Pollock, editors (International Universities Press, Inc. 59 Boston Post Road, P.O. Box 1524, Madison, CT 06443-1524) $50.00 plus $2.75 postage and handling.

This second volume of *The Course of Life* represents a revision and expansion of the 1980 version published by the U.S. Government Printing Office. Fifteen contributors address major challenges to understanding development in the second and third years of life, and to supporting healthy adaptation. A number of the chapters describe efforts to integrate data from the naturalistic observation of toddlers with insights from the reconstruction of early experience in the course of clinical work with children and adults. Sally Provence, Margaret S. Mahler, John B. McDevitt and Henri Parens all explore the relationship between longitudinal observation of children and theory building. Other authors, including Stanley Greenspan, Heinz Kohut, Alicia Lieberman, Peter Neubauer, Albert Solnit, and Marian Tolpin examine emotional disorders during the second and third years of life. In an essay that describes the developmental tasks of toddlerhood, the meaning of separation during this period for both mothers and children, and the roles of substitute caregivers, Erna Furman suggests a number of strategies that have helped caregivers to relieve the stress of separation and support the mother-child relationship.

Early Intervention Regulation: Annotation and Analysis of Part H (1990)—Wesley Brown (LRP Publications, 747 Dresher Road, P.O. Box 980, Horsham, PA 19044-0980) $25.00 plus $3.50 shipping and handling.

Wesley Brown is on the faculty of East Tennessee State University and chair of the Tennessee Interagency Coordinating Council of Part H of the Education of the Handicapped Act Amendments of 1986 (P.L. 99-457). In this 196-page volume he presents and annotates five Part H documents: the legislative history from House Report 99-860; the Part H legislation from P.L. 99-457; the final regulations for Part H, with current published corrections; the referenced regulations from Part B on confidentiality; and the regulations from the Family Educational Rights and Privacy Act. In addition to the annotations, the volume includes a discussion of the legal regulation of early intervention services; the author's analysis of 18 topical issues addressed in the Part H regulations; an annotated lexicon of definitions of terms used in the legislation; and a topical index to the regulations.